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Homelessness, Substance Abuse, and Perceived Barriers to Accessing Health Care Services

by

Karen Patricia Forss

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of Master of Science

Centre for Health Promotion Studies

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Faculty of Graduate Studies and Research

The undersigned certify that they have read, and recommend to the faculty of Graduate Studies and Research for acceptance, a thesis entitled 'Homelessness, Substance Abuse and Perceived Barriers to Accessing Health Care Services' submitted by Karen P. Forss in partial fulfillment of the requirements for the degree of Master of Science.

Abstract

Homelessness and substance abuse has become a pervasive issue within Canadian society. The incidence of both has increased and greatly affects the health of those who are involved. In this study 13 participants were interviewed to explore interrelationships among homelessness, substance abuse, and health care services. Participants were recruited from the Royal Alexandra Hospital or the George Spady Shelter in Edmonton, Alberta. The Addiction Severity Index and a semi-structured interview were completed, providing information on demographics, medical issues, perceived health status, barriers to using health care services, substance use, legal issues, family history, education, social support and psychiatric history. The sample reported accessing formal health services infrequently, despite the finding that many had multiple medical issues. Many respondents perceived they were healthy relative to their peers. These findings suggest that positive perceptions of health status relative to other homeless people may act as a barrier to accessing health care services.

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Chapter 1

Homelessness: An Introduction

Researchers in the United States have conducted a few large surveys on municipal homelessness, which included prevalence and incidence information on alcohol and illicit drug use. In contrast, very few Canadian studies have focused on urban homelessness and even fewer emphasize substance abuse and homelessness. Barriers, use, and access to health care services have been studied in the U.S.A. and Canada in the general context of homelessness, but virtually no studies have investigated access to health services among substance using homeless populations. The goal of this research is to fill these gaps in the literature and to describe information on links between homelessness, substance abuse, and access to health services in Edmonton, Alberta. In order to set the context for the research, this chapter reviews American and Canadian research on the general topics of homelessness, medical problems, and access to health care services among homeless and homeless substance abusing populations.

Research Questions

The purpose of this study is to characterize a sample of homeless substance using individuals in Edmonton, to identify their need for and use of health care services, and to document any perceived barriers to accessing those services. Existing literature suggests that individuals who are homeless and who also misuse substances have greater health care needs but do not utilize health care services as often as non-homeless members of most

communities. In-depth information from homeless substance abusers themselves would be extremely beneficial in determining use of services, barriers to services and in planning primary health care interventions and programs.

This exploratory study has the following goals:

1) Gain an understanding of the history and present use of alcohol and/or illicit drugs along with social history and support among the homeless substance abusing population.

2) Understand the present issues and personal perspectives in accessing health services, and to provide insight into what may reduce barriers and promote intervention and access to treatment and support for homeless substance abusers. As well, some of the perceived barriers that homeless substance abusing people have towards accessing formal health care services will be explored.

3) Explore social comparison processes in this population. Specifically, this study will explore whether a sample of substance misusing homeless individuals compare themselves to other substance misusing homeless individuals, and in doing so do not see imminent medical/ health issues that need to be addressed, nor a need to access health services. The role of their social, family and peer groups will also be investigated to determine whether social factors play a role in determining use of formal health care services. No specific hypothesis will be tested as this is an exploratory project.

Literature Review: Homelessness

The following literature review consists of two sections. The first section provides an overview of recent literature describing the incidence and prevalence of homelessness, medical and health issues

related to homelessness, health service use among the homeless, and theories of homelessness. The second section focuses specifically on the incidence of alcohol and drug use among the homeless. Health ramifications of alcohol and/or drug use are addressed through a systematic review of 32 articles that studied homeless alcohol and/or drug users. This second, focused, review was used to determine 1) trends in the empirical literature on homelessness and substance abuse, 2) typical methods used to study this hard to reach group, and 3) whether any of these studies attempted to evaluate or assess perception of health and use of health care services. This information was used to develop the methodology used for the present study.

Homelessness: General Issues and Definitions

Homelessness has been described as an ever increasing and pervasive problem across the United States (Baumohl, 1996; Wright, & Weber, 1987). Rossi (1989) defined homelessness as "not having customary and regular access to a conventional dwelling; it applies to those who do not rent or own a residence" (p. 10). Baumohl (1996) provided a more detailed definition of homelessness including the "literal" homeless who are people living on the street, in abandoned buildings, or in shelters, and "at imminent risk" of homelessness, which includes people who have precarious housing arrangements (single room occupancy hotels, staying with friends) or who have an imminent discharge from an institution with no prospects or resources to keep themselves from becoming homeless. Although these definitions are relatively clear, one problem with them relates to how the terms are qualified. In particular, one can

ask: "who sets the standard of what is affordable or safe housing, and what defines accessibility?" Prevalence estimates of homelessness in urban North America are strongly affected by how these terms are defined.

Prevalence of Homelessness in American Cities

Prevalence estimates of homelessness in the United States vary from approximately 600, 000 people in 1984 (Baumohl, 1996) to 26, 000, 000 in 1993 (Link, 1994). Wright and Weber (1987) note that estimates of the number of homeless Americans vary between 350 000 to 3-4 million people, depending on the operational definitions of homelessness used by different researchers. Baumohl (1996) suggests that increasing numbers of homeless people in cities such as New York and Philadelphia can be attributed to overall population growth in urban areas. New York city homeless estimates increased by 1.17% from 1987-1988; 2.21% from 1987 to 1990; and 3.27% from 1987 to 1992 (Baumohl, 1996). The number of homeless in Philadelphia increased .96%, from 1987 to 1990, and 2.77% from 1987 to 1992 (Baumohl, 1996). These trends are duplicated in other urban areas, and Baumohl attributes such increases to overall population growth in American cities.

The homeless population has changed dramatically over the past 30 years. Thirty years ago many homeless individuals were characterized as 'skid row alcoholics', consisting mainly of middle aged, Caucasian men who drank excessively (Rossi, 1989). However, throughout the 1980's and 90's, this population has become increasingly heterogeneous. The majority of homeless are

still male and single; however, they are younger (mid thirties), are often a visible minority, have higher levels of education, use alcohol less and other drugs more, and include greater numbers of women, children and families (Wright & Weber, 1987; Dennis, 1999).

Rossi's (1989) Chicago study reported that the average age of homeless individuals in Chicago was 36.1 years, with 45.8% being black, 37% having grade 8-11 education and 31.6% having grade 12 education. Rossi (1989) describes this population as having low levels of employment (29%), low average monthly income levels ($164.61 per month), and having been homeless for an average of 25.6 months. As well, recent U.S. data indicates that male veterans make up a more significant sub-set of homeless individuals in major American urban centres today compared to 30 years ago (Wenzel et al., 1995).

Prevalence of Homelessness in Canadian Cities

Homelessness in Canada has been on the rise as well. In 1996, approximately 26 000 people used the Toronto shelter system, with about 3100 people using the system on any given day (Mayor's Homeless Action Task Force, 1998). The City of Calgary reported in their May 2000 survey that 1296 homeless individuals live in that city, which is a significant increase from 461, 615, and 988 reported homeless individuals in 1994, 1996, and 1998, respectively (Calgary Homelessness - Year 2000 count). An Edmonton task force on homelessness reported that in March 2000, 1125 homeless individuals resided in this city, comprising approximately .14% of the Edmonton city population (Edmonton Community Plan on Homelessness, 2001).

Across Canadian cities, task force surveys and research reports indicate that the majority of homeless individuals are single white males who are between the ages of 25-44 (Calgary Homelessness - Year 2000 count, Edmonton Community Plan on Homelessness, 2001; Mayor's Homeless Action Task Force, 1998; Acorn et al., 1993). As well, Toronto, Edmonton, and Calgary each noted increasing numbers of women, children, youth, and families within their urban homeless populations. These descriptions of the homeless population parallel data reported from U.S. cities; however, there are striking differences in racial composition. In the U.S., for example, visible minorities were more likely to be homeless, while in each of the three Canadian cities reviewed earlier, Caucasians predominate. In addition, among visible minorities, African Americans are more likely to be homeless in the U.S., while in Canada, the most prominent minority noted within the homeless population are Aboriginal people. Toronto reports that aboriginals make up 15% of their homeless population, and that the number of aboriginal individuals comprising low income and homeless groups within their city is on the rise (Crowe & Hardill, 1993). Calgary reports that 20% of their homeless population consists of aboriginals, while Edmonton reports the largest proportion of aboriginal homeless individuals at 40%, (Calgary Homelessness - Year 2000 count, Edmonton Community Plan on Homelessness, 2000).

All Canadian cities indicate a disproportionate number of Aboriginal people in homeless populations, compared to aboriginals in the general population. Existing Canadian data did not indicate veterans as a subset of their homeless populations, nor did they

relate homelessness to trends in alcohol or illicit drug use; therefore, it is difficult to determine if Canadian homeless populations have followed similar trends as the United States over the past 30 years.

Medical Issues Among Homeless Populations

The existing literature consistently indicates that homeless individuals have much higher levels of mortality and morbidity than people who are not homeless, regardless of the country or city studied (Barrow et al., 1999; Wood et al., 1997; Crowe et al., 1992; Vredevoe et al., 1992; Breakey et al., 1989; Rossi, 1989; Wright & Weber, 1987). For example, Barrow et al. (1999) reported that in the U.S., the death rate for homeless people is 2-3 times greater than the mortality rate for the general population. These authors proposed that increases in the mortality of the population reflects increased intravenous (IV) drug use, alcohol use, and decreased access to health care services among homeless individuals. A total of 41% of the Chicago homeless sample studied by Rossi (1989) reported a chronic physical disorder, 36.8% reported bad health, 23% reported injuries, 32.5% reported they were too disabled to work , 28.8% reported mental health problems, and 32.7% reported alcohol and drug use. Wright and Weber's (1987) findings from their 19 city National U.S. cross country survey parallel Rossi's results; 40% of the homeless in their sample reported a chronic illness or disability. As well, Dennis et al. (1999) in their Washington D.C. study reported that 70% of the D.C. homeless population experienced at least one medical problem. Vredevoe et al. (1992) found that 46% of homeless people in Los Angeles had respiratory problems, 15% had cardiovascular disease and 21.2%

had physical injuries. Harris et al. (1994) reported that 53.5% of the homeless in Detroit indicated gastrointestinal problems, 40% had eye problems, 60.8% had alcohol problems, 75% had lost adult teeth and 63% had dental problems.

Canadian information derived from the Toronto Street Health Report (Crowe et al., 1993) also indicates that the homeless experience greater mortality and morbidity than the general population. For example, in comparison to the general population of Toronto, homeless people in that city were 6 times more likely to experience epilepsy, four times more likely to have emphysema and chronic bronchitis, and two times more likely to not receive dental care (Crowe et al., 1993). This report also indicated that 40% of homeless individuals surveyed had been a victim of physical assault, 20% had been raped and 40% had no health care cards (Crowe et al., 1993). A report from Vancouver claimed that 58.1% of their homeless expressed having dental problems, 52.4% indicated general health problems and that 43.6% of the homeless had medical problems that required medical attention, (Acorn et al., 1993).

Numerous American studies have investigated mental illness among homeless individuals. The prevalence of mental illness reported in individual studies reflect the type of measurement used and vary from between 13.4% in Cook County Illinois (where the measurement was based on past medical treatment for mental health issues; see Johnson et al., 1995) to 91% in Baltimore (where substance abuse was included with other Axis 1 DSM-IV mental diagnoses; see Breakey et al., 1989). North et al. (1998) found that

in St. Louis, early onset of homelessness was associated with schizophrenia, depression and generalized anxiety disorder. Winkleby et al. (1992) reported that individuals who were homeless for more than 5 years had higher rates of psychiatric hospitalization compared to other homeless individuals, and that homeless people that had no psychiatric impairment prior to being homeless were more likely to develop a psychosis while homeless. Schutt et al. (1988) reported that in Massachusetts, homeless women experienced greater psychiatric problems and men experienced more problems with alcohol. Individuals who had a dual diagnosis of alcohol and psychiatric illness were more likely to live on the streets and experience greater medical health issues. As well, in a study of homeless individuals in Los Angeles, Gelberg et al. (1988) demonstrated that those with previous psychiatric hospitalization were homeless longer, had worse mental health status, used alcohol and drugs more often and were more involved in criminal activity than other homeless people.

In summary, there are obvious discrepancies in prevalence rates across cities due to the economic, social structure, and environmental conditions of each individual city, as well as different methodologies and definitions of homelessness, medical, and psychiatric problems used across studies. At the same time, however, Canadian and American data consistently show that homeless populations are in high need of health care services secondary to their poor health and higher mortality rates.

Homelessness and Health Care Services

Because of the greater incidence of medical problems, access to health care services for the homeless (or lack thereof) has been outlined as a pressing issue in a number of task force reports and some research reports. Brickner et al. (1985) identified barriers for the homeless in accessing health care services, including: negative attitudes of the staff towards the homeless, lack of medical coverage, harassment, inadequate transport to and from facilities, and inability of these services to address the needs of this population. Beckman-Murray (1996) argue that many homeless people do not access health care services as it is not a priority for them. Beckman-Murray (1996) elaborate that many homeless individuals are more concerned about obtaining basic food, clothing and shelter, and that health care services necessarily come second. For this sub-set of the general population, health care is used as a last resort in acute and emergency situations (Beckman-Murray, 1996). This use of health care services mirrors a similar reduction in use of health care services in some developing countries, where basic human needs become the priority over general health care (Arole & Arole, 1994).

Crowe and Hardill (1993) reported that the homeless in Toronto face a number of barriers when accessing health care services. These barriers include frustration in not being taken seriously, not having their problems investigated thoroughly enough, rude staff, and financial barriers. The City of Calgary identified barriers to health care specific to their aboriginal homeless population, including transportation and distance issues, lack of knowledge of services available, cultural and language

barriers, previous negative experiences, costs, discrimination, lack of support, gaps in services, and a general mistrust of health and social services (Calgary Homeless Year 2000 count). The Edmonton report described their aboriginal homeless population as 40% of their total, and that 70% of the aboriginal homeless live on the street (Edmonton Community Plan on Homelessness, 2000). This report also claimed that a large percentage of aboriginal homeless people live on the street as a result of unfamiliarity with services available, inappropriate services, and discrimination when trying to access services (Edmonton Community Plan on Homelessness, 2000).

The literature reviewed in this section suggests that Canadian and American homeless populations are similar with respect to certain demographics, medical issues, and barriers in accessing services, but are very different in other respects. Canadian data were obtained primarily from secondary, 'grey', sources, whereas, American data were mainly obtained from primary research. As well, the United States and Canada have very different political institutions, social service institutions, and health care policies, which heightens differences across countries with regards to costs of treatment, health care, housing, welfare programs, and other social supports. Canada's homeless population differs as well in ethnic composition, and thus cannot be directly compared to U.S. data. Finally, Canadian data did not report or identify the prevalence of, or changes in alcohol or drug use, and it is therefore difficult to determine whether substance abuse is rising or declining among the homeless population.

Theories of Homelessness

The literature proposes two main types of factors that cause homelessness, corresponding to structural causes and personal causes (Morris, 1997; Wright et al., 1987). Structural causes refer to the way that society structures opportunities for employment, shelter, and health care. Examples included decreased affordable housing, decreased institutionalization, increased unemployment, low incomes, discrimination by landlords, allocation of resources to promote wider income inequality gaps, adult-only facilities, and rent increases (Calgary Homelessness - Year 2000 count, 2000; Edmonton Community Plan on Homelessness, 2001; Mayor's homeless Action Task Force, 1998; Morris, 1997; Youssef et al., 1988; Wright et al., 1987). All of these factors have been argued to contribute to urban homelessness. In contrast, personal causes refer to factors over which individuals have some control, including: marital breakup, dysfunctional families, alcohol and drug use, and gambling (Calgary Homelessness - Year 2000 count, 2000; Edmonton Community Plan on Homelessness, 2001; Mayor's Homeless Action Task Force, 1998; Morris, 1997; Wright et al., 1987).

Any one of these structural or individual factors or a number of them together may lead to a homeless situation, especially among those who are already vulnerable. The majority of these reports place the ultimate responsibility of homelessness on the lack of affordable, accessible and appropriate housing (Federation of Canadian Municipalities, 2000). The Federation of Canadian Municipalities (2000) argues that loss of adequate housing should be

considered a violation of a basic human right to shelter; which is reinforced through the World Health Organization's definition of health as one that includes adequate shelter for all (World Health Organization, 1986).

Structural and personal factors can work together to facilitate homelessness. For example, changes in social resource allocation, lack of affordable housing, and declines in incomes can place increased stress on individuals, which in turn, can exacerbate their situation (Morris, 1997). Morris (1997) claims that individuals of lower socioeconomic status, with long standing personal problems, are the most vulnerable individuals to become homeless. On this view, the most vulnerable in our society are pushed down further and compete for very scare resources such as affordable housing. Within Canada it has been demonstrated that rents have increased by 20% between 1989 and 1999, but in the same time period income has increased by only 2.7%, and that vacancy rates have dramatically fallen across almost all Canadian cities, (Federation of Canadian Municipalities, 2001). These data reinforce the idea that as homelessness has increased so has the cost of renting/buying homes, while income and vacancy rates have declined.

Theories of chronic and ongoing homelessness are described by Grisby et al., (1990) and include *entrenchment* and *disaffiliation processes*. The Entrenchment and Disaffiliation Process theory purports that as one becomes homeless that person experiences decreased social support, increased affiliation with other homeless people, increased isolation and dysfunction, and increased functioning outside of traditional roles and norms, all of which lead

to chronic homelessness. Morris (1997) concludes that chronic homelessness is a cycle where individuals become increasingly more vulnerable, with increasing amounts of isolation and shame, making it difficult to return to a more conventional lifestyle.

These processes of entrenchment and disaffiliation are provocative and suggest that structural and personal factors operate in a dynamic way in the process of becoming homeless and maintaining homelessness. However, the role of substance abuse in theories of homelessness has not been well described. The second literature review section, following, will evaluate recent studies that examine substance use and homelessness, and propose possible reasons for the high prevalence of substance abuse amongst this population.

Literature Review: Homelessness and Substance Use

Chronic and acute alcohol and illicit drug use has long been known to be associated with various medical problems and disease. Examples of alcohol related diseases include Korsakoff's syndrome, brain atrophy, cardiomyopathy, liver disease, pancreatitis, gastrointestinal ulcer, fetal alcohol syndrome (McKim, 1997), as well as motor vehicle accidents and trauma (Blake et al., 1997). Examples of medical problems associated with illicit drug use include IV drug related diseases such as HIV, Hepatitis B and C, respiratory disorders (Wills, 1997), tachycardia, hypertension, convulsions, cardiomyopathy, brain damage, death, (Wills, 1997; McKim, 1997) and motor vehicle accidents and traumas (Grilly, 1998).

The financial costs of alcohol and drug use/abuse need to be

illustrated in order to demonstrate the incredible impact that these substances have not only on the individuals using them but also on society as a whole. The total Canadian costs in 1992 for alcohol and illicit drug use were 6.8 billion dollars and 1.4 billion dollars respectively (Single et al., 1996). These costs include lost productivity, direct health care costs, and law enforcement costs.

Although it is clear that acute and chronic abuse of alcohol and/or illicit drugs can cause many severe and disabling illnesses and has a profound economic impact, the relationships between homelessness and substance abuse have not been extensively investigated in relation to theories of homelessness reviewed in the previous chapter. In order to determine the state of current research on the interaction of homelessness and substance use, a systematic literature review was conducted. The literature review was designed to locate articles that specifically addressed the dual issues of homelessness and substance abuse.

These 32 articles were characterized in depth to assess their recruitment and sampling methods, their data collection procedures, and main findings. It was important to determine whether or not there was consistency across studies with methodology, sampling and results. This information was relevant in assisting the researcher to develop sampling methods, determining useful and relevant interview guidelines, and in setting inclusion/exclusion criteria for the study.

Method

To obtain relevant research articles, a search was conducted across Healthstar, Medline, Cinahl and PsychInfo databases.

Initially the headings of homelessness, alcohol, illicit drugs, and healthcare services were used. Under homelessness, the following related terms were exploded: homeless, street-living, non-housed, and urban-homeless. Under alcohol, ethanol, alcoholism, alcohol abuse, substance abuse and use, alcohol disorder were exploded; and for illicit drugs, specific illegal drugs were listed, along with exploded terms of substance use and abuse. Results from the main search headings were combined, and the resulting searches were limited to the past 20 years (1980-2000), human studies, and written in English. This process yielded 65 references and abstracts that were read for possible inclusion in the main review of the literature[1]. Of these 65 references, 32 were selected for a detailed review.

Articles were included at this stage if they (1) presented general issues of homelessness, substance use and perceived barriers to health care services. Very few articles investigated perceived barriers to formal health care services across both substance abusers and homeless people; thus, articles that made general assumptions for the perceived barriers to services for either homeless individuals or substance abusing individuals were included; (2) presented original data addressing the issue of homelessness and substance use; and (3) explicitly defined measures of homelessness, measures of substance use, and measures of perceived barriers to health care

[1] Additional grey literature was obtained through internet searches on municipal web sites, and through contacting offices of municipal governments for information. Only one of these articles described homelessness along with perceived barriers to health care utilization (City of Calgary report on Homelessness, 2000) and none of them looked specifically at the issue of substance abuse among the homeless.

services.

Articles were excluded if they (1) focused only on addiction treatment among homeless populations (e.g., Shipley et al., 1989; Schumacher et al., 1995; Wright et al., 1995; Milbey et al., 1996), (2) if they focused primarily on mental health disorders rather than substance use disorders (e.g., Hopson et al., 1996; Nyamathi et al., 2000; Pollio et al., 2000), (3) did not provide original data on substance abuse and homelessness, and (4) provided only general assumptions to accessing healthcare services.

Of the 32 articles meeting the inclusion criteria, 5 of these papers utilized data from the same survey source in New York City. Two of these 32 studies utilized the same data set from a Cook County Illinois survey, two others used data from the same Santa Clara California data set, and two more referred to data from the same Minneapolis survey information.

Coding of Articles

Each of the 32 articles was reviewed and coded using the following categories: population (city and country of origin, sample characteristics), article purpose, definition and measure(s) of homelessness, alcohol and other drug use measures assesssed, and presence or absence of barriers to health care services. All of the articles reviewed were non-experimental and were classified as using cross-sectional, retrospective, or prospective research designs and whether or not they included a comparison group. Table 1 presents a summary of the information obtained from each study as a result of coding.

Table 1: Literature Review

Author	Sample	Recruitment	Substance Use Measure	Barriers to Service
Padgett et al., 1990	M=695, F=137	Narrow	SMAST/ Interview	General Homeless Pop.
Padgett et al., 1992	M=695, F=137	Narrow	SMAST/ DIS/ Interview	Substance Abusing Ind.
Padgett et al., 1995	M=695, F=137	Narrow	SMAST/ DIS/ Interview	Not described
Struening et al., 1990	M=695, F=137	Narrow	SMAST/ Interview	Not described
Barrow et al., 1999	M=695, F=137	Narrow	SMAST/ Interview	Not described
Acorn, 1993	M=88, F=36	Narrow	Interview	Not described
Caslyn et al., 1993	M=165	Narrow	SMAST	Not described
Calgary Report, 2000	Not stated	Narrow	None	Homeless & Aboriginal
Harris et al., 1994	M=82, F=34	Narrow	Interview	Not described
Winkelby & White, 1992	M=1268, F=169	Narrow	DIS/ NIMH/ Interview	Not described
Winkelby et al., 1992	M=1268, F=169	Narrow	DIS/ Interview	Not described
Little et al., 1996	M=123, F=12	Narrow	Interview/ Prof. Assess.	Subst. Abus. & Homeless
Cohen et al., 1996	N=50	Narrow	None	Not described
Wright et al., 1987	N=11,797	Narrow	Interview/ Prof. Assess.	Not described
Vredevoe et al.,1992	M=1148, F=108	Narrow	ICD-9	Not described
Ageriou et al., 1995	N=839	Narrow	ASI/ GDI	Not described
Wenzel et al., 1995	M=429	Narrow	Interview	General Homeless Pop.

Author	Sample	Recruitment	Substance Abuse Measure	Barriers to Service
Gelberg et al., 1988	N=529	Broad	Interview	Not described
Rossi, 1989	N=722	Broad	Interview	Not described
Grisby et al., 1990	M=149, F=17	Broad	Interview	Not described
Crowe et al., 1993	M=352, F=106	Broad	None	General Homeless Pop.
Osborne et al., 1993	N=198	Broad	interview	General Homeless Pop.
North et al., 1998	M=600, F=300	Broad	DIS	Not described
Bray et al., 1999	M=640, F=202	Broad	DIS/ Interview	Not described
Fichter, et al., 1999	M=265	Broad	DIS	Not described
Benda et al., 1988	N=345	Broad	Interview	Not described
Segal, 1991	M=417, F=85	Broad	BAL/ Interview	Not described
Johnson et al., 1995	M=343, F=138	Broad	Interview	Not described
Gregoire, 1996	N=338	Broad	Interview	Not described
Johnson et al., 1997	M=343, F=138	Broad	Interview	Not described
Sosin et al., 1997	N=535	Broad	Interview	Not described
Breakey et al., 1989	M=115, F=88	Broad	SMAST/ BAL	Not described

Notes. SMAST= Short Michigan Alcoholism Screening Test, DIS= Diagnostic Interview Schedule, ASI= Addiction Index, GDI= Global Depression Index, NIMH= National Institute of Mental Health Diagnostic Interview Schedule, Prof. Assess.= Professional Assessment, ICD-9= International Classification of Diseases 9th Revision, BAL= Blood Alcohol Level, Subst. Abus.= Substance Abusing.

Country of Origin

Eligible studies were found in the U.S.A., Germany, England and Canada. Only three of the 32 articles provided data on Canadian samples (9.4% of the articles reviewed). Articles included in this review that were taken from European samples made up 6.3% of the studies reviewed. Finally, 84.3% of the studies reviewed in this paper were from American research projects in American cities. The sample sizes ranged from n=50 (Cohen et al., 1996) to n=11, 797 (Wright et al., 1987).

Sampling Homeless People: Variation Across Studies

Narrow recruitment strategies. There was wide variability across studies in the way researchers recruited homeless individuals. About half (n=17 studies) used what could be called "narrow" recruitment procedures that provided relatively convenient access to the population. For example, 11 obtained their homeless respondents through sampling emergency and transitional shelters. By definition, these studies define the homeless population as one that exists only in shelters. As such, the information in these reports only reflect homeless individuals who are aware of and utilize the formal shelter support system. The five articles that utilized the same New York City data set used this recruitment method. One of the three Canadian studies sampled homeless individuals within a shelter system (Acorn et al., 1993), thus omitting the homeless residing on the street, abandoned buildings, or bus shelters. Winkleby et al.'s two studies on the Santa Clara homeless also recruited respondents using this method. Harris

(1994) and Caslyn (1991) both also obtained information from their homeless samples utilizing shelters in Detroit and St. Louis respectively. Finally, the city of Calgary report on homelessness count year 2000, completed their homeless counts by sampling only the shelters within their urban centre. The complete summary of results can be seen in Table 1.

Two of the 32 reports defined homelessness as not having a reportable fixed address. This definition is vague and is not clear in its definition of homelessness, except that no address was given. Both Little (1996) and Cohen (1996) use this definition to describe the population that they sampled in London and Los Angeles, respectively. Little et al. (1996) recruited their sample from the Emergency room at an acute care hospital in London. No further methods were used to determine location of residence, as their study was based on chart review. Cohen et al. (1996) recruited their sample from an "opportunistic" street sample. Cohen et al. (1996) was not clear on whether or not these homeless individuals resided on the street, stay in abandoned buildings, or shelters.

Of the 32 studies reviewed, four sampled homelessness individuals who utilize day programs or health services designed for low-income individuals. Wright and Weber (1987) sampled homeless individuals that participate in their 19 city Health Care for the Homeless program. Individuals participating in this program attend specific health care programs where the individuals themselves determine whether or not they are homeless. Wenzel (1995) sampled a very specific population of veteran homeless men. In sampling this group, Wenzel accessed homeless individuals

through Homeless Veteran's program in Los Angeles. Argeriou (1995) chose to assess homeless individuals accessing community detoxification programs in Boston, and Vredevoe (1992) sampled only homeless individuals who accessed an inner city medical clinic in Los Angeles.

A main limitation of these narrow recruitment strategies, is that many of those studies may be missing potentially large pockets of homeless individuals within their community. As well, the sub groups that they are missing may be the most at risk and hardest to reach and treat homeless individuals in their urban centres.

Broad recruitment strategies. In contrast, the other half of the studies (n=15 studies) reviewed used "broad" recruitment procedures that expanded the scope to include hard-to-reach homeless individuals. For example, Crowe's (1993) report on homelessness in Toronto defined their homeless population as consisting of individuals residing in shelters, day programs, on the street, outside, soup kitchens, meal providers, or in abandoned buildings. Other authors who utilized this definition for homelessness include Rossi's (1989) Chicago study, Bray's (1999) Washington D.C. study, North's (1998) St. Louis study, Fichter's (1999) Munich study, Grisby's (1990) Austin Texas study, Osborne's (1993) Austin Texas study, and Gelberg et al.'s (1988) Los Angeles study.

Six of the 32 references reviewed sampled homeless individuals from shelters, day programs, outdoors, soup kitchens and other meal provider services, abandoned buildings and bus shelters, single room occupancy hotels, and individuals residing in

the homes of friends or relatives for less than 2 weeks and not paying rent. Both of the Cook County Illinois research articles (Johnson et al., 1997; Johnson et al., 1995.) described their homeless sampling using these parameters, as did two of the other articles depicting homeless individuals from a separate Chicago survey study (Sosin, 1997; Gregoire, 1996). A survey from Alaska completed in 1991 (Segal, 1991), and another research study from Richmond Virginia (Benda, 1988), described their homeless recruitment methods as involving sampling from shelters, the outdoors, hotels/motels, abandoned buildings, meal providers, drop ins, and day programs.

One of the 32 studies reviewed included all of the above in its definition of homelessness as well as the prison population. Breakey et al. (1989) described its Baltimore homeless by including shelters, day programs, meal provider services, the outdoors, single room occupancy hotels, abandoned buildings and prison. This was the only study to include this population, and according to their study, numerous members of the prison population face immediate homelessness upon release, and faced it prior to prison.

These last two groups of sampling methods are far more inclusive than those who restrict themselves to only shelters or clinics; and thus more information can be derived from sampling the numerous places that homeless people may visit or reside.

Definitions and Measures of Substance Use/Abuse/Dependence

The numbers of homeless alcohol and drug users also varied across studies. It is clear that different areas and cities of the U.S.A. and Canada use different methodologies in each report; overall, they reveal that the percentage of substance abusers in the American

and Canadian homeless population ranged between 23% and 63% (Koegel et al., 1988; Wright et al., 1987). Most reports measured both alcohol and illicit drug abuse. Out of the 32 studies reviewed, 15.6% (5/32 studies) focused either entirely or primarily on alcohol alone, and 84.4% (27/32) addressed both alcohol and illicit drugs in their surveys and interviews.

Of the 32 studies reviewed, a variety of standardized clinical measures of substance abuse or dependence were used. Table 1 details the various measures used among the 32 studies. A total of 14 of the 32 studies reviewed (43.8%) utilized a standardized evaluation to determine substance use. Some studies utilized more than one instrument or took some measures from certain instruments that were more relevant for their purposes. Of the 14 studies using standardized evaluations, 9 (64.3%) also used an initial interview to determine substance use and social history, and 4 (14.3%) relied on sections from other standardized evaluations; however, the "other" standardized tests were not necessarily used to determine substance use, rather they were to determine general functioning and severity of problems. A total of 2 of the 4 studies that used two standardized evaluations also used interviews (Padgett et al., 1995; Padgett et al., 1992). The most common assessment used was the Short Michigan Alcohol Screening Test (SMAST) which was used in 7 reports: Barrow et al. (1998); Caslyn et al. (1991); Breakey et al.(1989); Padgett et al. (1992); Struening et al. (1990); Johnson et al. (1995); Padgett et al. (1990). Breakey et al. (1989) obtained Blood Alcohol Level readings and also used a general health questionnaire. Other common measures used

included the Diagnostic Interview Schedule (DIS) which provides DSM III and IV criteria for substance abuse and dependence diagnoses; this method was used by Winkleby & White (1992); Winkleby et al. (1992); Fichter et al. (1998); North et al. (1998); Bray (1999); Padgett et al. (1992); Padgett et al. (1995). Winkleby & White (1992) also included a question from the National Institute of Mental Health Questionnaire (NIMH) to complete their investigation of substance use and social history. Argeriou et al. (1995) used the Addiction Severity Index (ASI) along with the Global Depression Index (GDI). As well, one study within the group of 32 used ICD-9 codes to identify substance abuse/dependence in a retrospective chart review study (Vredevoe et al., 1992).

Other studies examined substance abuse using questionnaire methods and one-on-one interviews. Out of the 32 reviewed studies, 15 (46.9%) used personal interviews as their primary means of obtaining present and past substance use, symptoms and social history. One example is the Segal study (1991) which measured alcohol use through a self report questionnaire and interview, and validated these data with Blood Alcohol Measures (BAL). Benda et al. (1988) and Gelberg et al. (1988) both used self reports of previous and current alcohol use and prior treatment for alcohol and/or illicit drug problems; the studies differed in their measures in that Gelberg et al. (1988) also examined detoxification-related symptoms (delirium tremens, blackouts). Osborne et al. (1993) also used self report on current and past alcohol/drug use and hospitalizations; however, they also looked into self perceptions of their own and their peers' alcohol usage through self reports, or collected information on

previous hospitalizations for substance abuse or dependence (Sosin et al., 1997; Wenzel et al., 1995)

A few studies described in more detail the questions asked and how they related to substance use issues. Harris et al. (1994) asked their homeless sample detailed self report questions concerning past hospitalizations, past drug/alcohol use (daily vs. monthly) and amount of drugs consumed as per the Brief Symptom Inventory as part of the General Severity Index. Johnson et al. (1997) indicated that some of their alcohol/drug use indicators where similar to the SMAST but were not identical in all respects; however, they detailed initial age of onset of alcohol/drug use, first age of detox, first age received treatment for substance abuse/dependence and first age that substance abuse caused familial problems. Gregoire (1996) conducted a one on one interview to determine frequency, amount, symptoms and consequences of alcohol or drug use.

Rossi (1989) also measured previous hospitalization and/or treatment for alcohol /drug use; however, he included self report measures on whether or not alcohol use had affected respondents' ability to maintain or obtain employment. Wright et al. (1987) had a very different measure in that their cohort was obtained through 19 separate Health Care for the Homeless clinics across the U.S.A. Wright et al. (1987) used the health care providers assessment of individuals through examination, interview, and observation, as the determination of an alcohol or drug problem. The judgment was based on previous hospitalization or treatment for substance abuse/dependence, individual's statement of a problem with alcohol or drugs, a previous diagnosis of substance abuse/dependence, or if

the individual showed up intoxicated or stoned at the clinic. Little et al. (1996) as well utilized the assessment of the health care professional to determine alcohol/drug use as the individuals were brought into the emergency room at their facility.

Three of the 32 studies (9.4%) did not include substance abuse measures at all, but were focused on the issue of homelessness (Crowe et al., 1993; Calgary homeless report-2000; Cohen et al., 1996). Crowe et al. (1993) and Cohen et al. (1996) both used one on one interviews to obtain their data, whereas the city of Calgary (2000) used surveys and focus groups.

Barriers to Health Care Services

Only 7 of the 32 studies reviewed explicitly examined barriers to accessing health care services. Osborne (1993), Crowe (1993), Padgett et al., (1995), Little et al. (1996), Wenzel et al. (1995), Padgett et al. (1990), and the city of Calgary homeless report (2000) each attempted to describe in varying degrees, perceived barriers to accessing the health care system. The summary of the seven articles that evaluated barriers to health care services are included in Table 1. Table 1 shows that five of the seven articles described barriers to formal services for the homeless population in general (Crowe et al., 1993; Osborne et al., 1993; Padgett et al.,1990; Wenzel et al., 1995; The City of Calgary homeless report year 2000), one of the seven articles depicted barriers for a substance abusing population only (Little et al., 1996), and one of the seven articles assessed barriers for homeless substance abusers (Padgett et al.,1995). The two studies that investigated substance-abusing homeless respondents reported that

their need for health care services was greater than the broader substance abusing population, but were less likely to access those services.

Many U.S. studies reported the degree and extent of health care services used by homeless populations; however, few have been specific to the subgroup of the substance abusing homeless and their use and/or non-use of health care services. Breakey et al. (1989) identified some barriers to accessing and using health care services for the homeless; however, many of these barriers were anecdotal, hypothesized, and did not come from a specific substance using homeless subgroup, such as Padgett et al. (1995), who evaluated the use of emergency room services by homeless populations. In this study, homeless individuals with high levels of alcohol abuse and dependence demonstrated less use of emergency rooms, despite their more urgent need for health care services. Little & Watson (1996) reported that in the London homeless population, only about 50% were aware of the health care services and their location, and a large proportion of those individuals were utilizing alcohol.

Summary

Of the studies reviewed, there was no consistent definition of homelessness and no consistent methodology used to measure substance use/abuse across studies, making it difficult to compare and contrast findings across studies. Most of the studies focused on alcohol abuse, rather than illicit drug use, and provided little information on homeless substance abusers and their particular issues in accessing formal health care services. Struening and Padgett (1990), Fischer and Breakey (1987), Schutt and Garret

(1988), McCarty et al. (1991) and Crowe et al. (1993) all demonstrated that homeless individuals who misuse alcohol and/or illicit drugs have poorer physical and mental health and are in greater need for health care services than other homeless people. This suggests that there is a need to determine the prevalence of use of health care services among the substance abusing homeless population, and if their use is lower than expected for the needs, to examine why. This thesis will address these limitations and issues. For example, the present study conducted research that is inclusive of both alcohol and drug use, men and women, sampled from various sites (hospitals and shelters), using both standardized assessment of alcohol and other drug abuse with a specific focus on how and why or why not homeless substance abusing individuals access health services.

Theoretical Perspectives on Homelessness, Substance Abuse, and Health Service Use

The relationship between alcohol and other drug use and homelessness has been specifically evaluated in some American studies. Gregoire (1996) identified subtypes of individuals exhibiting alcohol and drug abuse and homelessness. Gregoire (1996) found that individuals with the highest level of drug and/or alcohol use had the longest period of continuous homelessness and were more likely to have remained homeless at six month follow up than individuals with lower levels of alcohol and drug use.

Morey and Skinner (1986) identified two approaches to classify alcohol and drug use problems. These two models are dimensional and categorical. Categorical models of alcoholism state

that different types of alcohol use are unique and mutually exclusive and therefore, that individuals can be placed into unique subtypes. Dimensional models view alcohol use as an associated problem that occurs along a continuum; for example, that alcoholism occurs in phases with each stage identifying an increasing severity of the disorder. Gregoire (1996) identified 8 sub-types of substance abusers within their homeless population including: (1) family contact (no alcohol problems, short periods of homelessness, most often young, female and married), (2) poly-substance (drank alcohol and used drugs regularly, frequent contact with family and other homeless people, and > 1 year homelessness), (3) low-problem (minimal alcohol and/or drug use, homeless for > 1 1/2 years, less contact with family and other homeless people), (4) mental health (drinks alcohol and has one or more symptoms of alcoholism, minimal illicit drug use, little family contact, more frequent contact with other homeless people, hospitalized for mental illness), (5) high drug use (under 30 years old, little family contact, good physical health, > 1 year homelessness, moderate alcohol use, frequent drug user), (6) poor health (poor physical health, < 1 year homeless, minimal alcohol or drugs), (7) employment (drank infrequently, unlikely to use drugs, worked from 1-2 weeks in past month, short periods of homelessness), and (8) high alcohol (most likely aboriginal, committed crimes, high contact with other homeless people, homeless > 3 years, consumed great deals of alcohol, binged frequently, unlikely to report mental health problems or to use drugs, poor physical health). Within these groups high alcohol and the poly-substance users were the individuals most

likely to be locked into long-term homelessness (Gregoire, 1996).

Johnson and Freels (1993) reviewed two influential theories of substance abuse and homelessness: social selection and social adaptation. Social Selection theory proposes that homelessness is the final result of a process where an individual's social and economic resources are gradually depleted, as a consequence of their substance abuse and other personal disabilities (Baumohl, 1996). Consistent with this perspective, Winkleby et al. (1992) suggest that substance abuse alone can put an individual at an increased risk for homelessness. In contrast, Social Adaptation theory proposes that alcohol and drug use are more likely to be a consequence rather than a cause of homelessness (Johnson et al., 1997). From this perspective, alcohol and other drug use is thought to be a means of coping and adapting to life on the streets, and a way of dealing with the environmental and social stresses of homelessness (Wiseman, 1975).

Socialization within the subculture of homelessness may involve pressures on individuals to begin using alcohol or drugs (Snow et al., 1993). It could also be surmised that homeless individuals may utilize alcohol or drugs as a means of self medicating for physical or psychiatric illnesses (Docter, 1967). Consistent with this perspective, Sosin et al. (1997) proposed that homeless individuals become more vulnerable to using alcohol and/or drugs.

Empirical evidence related to these theories is mixed. In support of Social Selection theory, Koegel & Burnam (1988) reported that approximately 80% of their Los Angeles homeless sample

exhibited symptoms of substance dependence prior to the onset of homelessness, compared to 25% who stated that they developed their first symptoms of alcohol dependence after the onset of homelessness. North et al. (1998) also reported data supporting Social Selection Theory, specifically, that the majority of chronic alcohol-using homeless individuals in their study had their alcohol use onset preceding their homelessness. In contrast, Winkleby et al. (1992) determined that the homeless population in their study had no difference in alcohol use preceding or following their onset of homelessness, and is therefore more supportive of a bi-directional theory.

Johnson and Freels (1997) argued that the two models are not mutually exclusive and when used alone, neither can adequately explain substance use and homelessness. Johnson and Freels (1997) proposed that a bi-directional theory that views substance use and homelessness as risk factors for each other needs to be identified and developed in order to clearly define the relationship between the two.

Although the theories reviewed in the previous section are important, neither was specifically designed to address why homeless substance abusers do or do not seek out health care services. Anderson and Newman (1973) described a theory for accessing health care services that includes need, predisposing factors, and enabling factors. Anderson and Newman (1973) propose that need (ie., illness) is the greatest influence on individuals to access health care services. Predisposing factors reflect sociodemographic characteristics, while enabling factors

represent resources required to access services (i.e. income or medicare benefits). Padgett et al. (1990) reported that in a group of homeless adults, illness (need) was the greatest predictor of health care service use, although enabling factors did play a small role in obtaining medical and drug services.

Wenzel et al. (1995) also reported that for the homeless veteran population in Los Angeles, illness (need) was the most significant predictor of health care utilization; after which predisposing social structure factors were also significant. On the other hand, Padgett et al. (1990) found that chronicity of alcohol use and homelessness led to decreased use of emergency rooms, even though this group has been identified as having greater health care needs (Vredevoe et al., 1992; & Rossi, 1989; Wright et al., 1987). Thus, one must ask the question: why don't homeless substance abusers, who may have high medical needs, not access formal health care services?

Wood et al., (1997) reported that homeless individuals who engaged in alcohol and substance misuse frequently encountered problems in registering themselves within the United Kingdom Medical System. In essence, people who were homeless and misused alcohol or illicit drugs did not use general practitioners to address basic health care issues, and therefore were unable to be followed up for treatment (Wood et al., 1997). These results are consistent with Anderson and Newman's (1973) view that enabling factors are important determinants of access to health care services. In this case, alcohol and illicit drug users who were homeless did not use basic medical services because they could not be registered with a

general practitioner for initial and ongoing care (Wood et al., 1997).

Osborne et al. (1993) proposed a theory of why homeless individuals do not access health care and treatment services. The theory described is termed the Adaptation Level Theory. This theory was coined by Helson in 1964 and is closely related to Multiple Discrepancies theory (Michalos, 1985). Both theories are based on social comparison, that is, when individuals compare themselves to individuals who are closest to their own situation in life in order to determine their own needs and beliefs (Osborne et al., 1993). Michalos (1985) states that an individual will alter their expectations in life to fit what is reasonable given their existing life circumstances; thus, a homeless person will no longer compare themselves to the housed person that they were, and starts to compare themself to others in their similar situation to determine what expectations are reasonable in their new life.

Osborne et al., (1993) propose that as an individual becomes more entrenched within the homeless population (based on time spent homeless and number of homeless friends), they compare their illness/conditions/disabilities with other homeless individuals. In comparing their disability to other homeless individuals they do not perceive health problems as severe, and therefore do not feel that they need to seek treatment. Housed individuals in society compare the illnesses of the homeless with themselves, and in doing so , find the disabilities of the homeless severe (Osborne et al., 1993). However, as the homeless become more entrenched within their homeless lifestyle, they only compare themselves with each other and do not perceive themselves as having severe disabilities or

illness. Therefore, the perceptions of the homeless substance users on their own health circumstances may also play a significant barrier in accessing health care services. If the homeless population do not perceive a need, then one cannot expect them to access those services. The degree to which the individual perceptions play a role in accessing or not accessing services needs to be explored.

The following sections of this paper will then attempt to: (1) gain an understanding of the history and present use of alcohol and/or illicit drug use along with respondent's social history and social supports, (2) determine whether the substance using homeless respondents utilized the formal health care system and if there were barriers to using the services, and (3) explore social comparison processes in the sample by determining whether or not respondents perceived that their own health was better or worse than others around them.

Chapter 2

Methods, Materials and Data Analyses

Introduction

The following chapter presents the methods, materials and data collection procedures used in the study. Inclusion and exclusion criteria are introduced, along with the methods of obtaining participation in the study. A protocol for the data collection for the project will be reviewed, followed by a description of data analysis procedures.

Sample

The study sample was obtained from the urban centre of Edmonton, Alberta. The initial proposal attempted to include participants from a number of sites including acute care facilities, shelters, and community resources in order to reflect the need to be inclusive when sampling this population; however, due to difficulties obtaining cooperation from all facilities, the sampling sites were reduced. The other sites approached were already involved in other projects and were unable to extend their time with this study. The Health Ethics Board had concerns over the interviewer's safety with accessing street samples, thus the street sample was not completed. The sample included both men and women and individuals that used alcohol and/or other drugs.

Recruitment sites. The study intended to evaluate individuals who experienced periods of homelessness and who abuse either alcohol or illicit drugs. The sample was obtained through two sites: (1) the George Spady Centre, and (2) the Edmonton Royal Alexandra Hospital emergency and in-patient services. If potential

participants were undergoing detoxification or severe withdrawal, the interview was postponed until the detoxification process was complete or under control. The Royal Alexandra Hospital (RAH) was used as a study site, since it provides detox and withdrawal services to residents of the inner city. The George Spady Centre was also utilized as it provides detox services and over-night accommodations to intoxicated individuals who are homeless.

Criteria for defining alcohol and other drug abuse. The emergency room and admitting doctors and other clinicians used their clinical judgment, based on patient history, self report, circumstances surrounding admission, and the physical and mental condition of the patient, to determine if they had a substance abuse related diagnosis. Participants in the study were selected based on the clinician's assessment that substance abuse was probable. The George Spady Centre accepted anyone into their facility as long as the individual stated or appeared intoxicated or high, and who had no other place to stay. The Centre provided a four-day detox service. The staff assessment for participant inclusion was based on the client's behaviour, physical and mental condition, and circumstances surrounding the admission of the client. This research study utilized the definition of each facility for determining substance abuse for its inclusion criteria.

Criteria for defining homelessness. Crowe et al. (1993) is the most recent published survey in Canada on homelessness in Toronto. They defined homelessness as someone "spending 10 or more nights of the previous 30 in a nighttime shelter; a public place like a park or stairwell; or having no place of his or her own, staying with

friends (or any combination of these)" (p. 22). For comparative purposes, the same definition of homelessness was used in the present study. Individuals participating in this study must have been homeless for 10 of the past 30 days as per the above definition. Each individual that met both the substance abuse criteria and the homelessness criteria were eligible for participation in the research.

Other inclusion and exclusion criteria Additional inclusion criteria are that the individuals participating in the study must be greater than 18 years of age, can be male or female, must be able to understand and speak English, must be current alcohol and/or drug users (i.e. past month), and able to follow simple directions and instructions. At the time of the interview/survey the individuals were non-violent, or non-abusive, able to understand and follow directions, and were able to speak coherently. Participants were excluded if they were at risk of becoming disruptive or violent, were incomprehensible, and/or needed emergency health services.

Procedure. The staff at the George Spady Centre and the Royal Alexandra Hospital screened potential participants for residency status and determined if they fit criteria for "homelessness". Participants accessed either the RAH or the Spady Centre in order to use their services (shelter, detox, or medical). Once participants were admitted, the staff at each facility inquired about their alcohol/drug use and residency status. If an individual fit the homeless and substance abuse criteria, the screening staff at each facility asked the participant if they would like to be part of the study and reviewed the information sheet with the individual. Staff at the hospital contacted the interviewer once appropriate

individuals were admitted or detoxing, agreed to be part of the study and were aware of what they study was about (via the information sheet). Once the interviewer was contacted, they would initiate the interview the same day (especially if the person was in the ER and was not going to be admitted), and complete the interview in a private office or hospital room. At the Spady Centre the interviewer contacted the staff on a weekly basis for 8 weeks to see if there were any willing participants who had been screened by the staff, agreed to participate and were aware of the study's intentions. The interviewer then asked the staff what the most appropriate time/day would be for the participant to complete the interview. Once the day/time was determined, the interviewer went to the Spady Centre, and the interview was completed there in a private room.

At the beginning of the interview the project interviewer (the researcher) read the contents of the information sheet to potential participants, giving the information sheet at the start of the interview, and leading the participants through the consent form prior to the interview (see Appendix 1 & 2). There were no adverse effects likely for participants in the study. The time burden of the interview was kept reasonable as to not place too many constraints or demands on the participants. The interviewer gathering the information was experienced in dealing with this population, was non-judgmental towards the participants and their lifestyle, and monitored the participant's comfort and well-being throughout the interview. Any concerns over the participant's health status or mental state was given priority over obtaining the interview data.

If there were concerns about a participant's mental or physical health the interviewer referred the participant to relevant treatment services. For example, during the final interview at the Royal Alexandra Hospital emergency room when the participant became diaphoretic and faint, an ER nurse was contacted immediately.

Thirteen single interviews were completed between the 2 facilities, with 4 interviews from the Royal Alexandra Hospital and 9 from the George Spady Centre. Power calculations for these sample sizes were inappropriate, as this was not meant to be a representative samples of the entire homeless population. No hypothesis was tested; however, a projected sample size of 15 is consistent with guidelines for interview studies proposed by qualitative researchers (Sandelowski, 1995).

Data Collection: Materials, Time and Personnel

The initial component of the interview consisted of an informal semi-structured interview to gain rapport, understand the state of affairs that led to respondents' current living situation and substance abuse. Within that interview, information concerning these individuals' perception of their own health and substance use, that of others in their community, their use of formal health care services, and their perceived barriers to accessing these services was explored.

The interview extended to self reported medical and psychiatric status of the participant and their perceptions of the medical and psychiatric conditions of their peers (see Appendix 4 for interview guide). In addition, the interview discussed in depth the

use of formal health services; under what circumstances would they access them and what circumstances would they not feel it necessary to access such services. For example: do they think that they or others in their community should use formal services more/less often? Why/Why not? Questions were also asked about perceptions of barriers to accessing and use of these services (i.e. distance to facilities, judgmental attitude of staff, discrimination, inappropriate treatment, lack of trust).

The second component of the interview consisted of the Addiction Severity Index (McLellan et al., 1992) which is a standardized evaluation of addiction, and exhibits good reliability and validity for studies using homeless individuals (Joyner et al., 1996; Zanis et al., 1994). The Addiction Severity Index (ASI) uses a semi-structured interview to assess 7 areas: substance abuse, medical status, family/social structure, psychiatric status, legal concerns, and employment and support (please see Appendix 6 for copy of ASI). Each ASI took approximately one hour to complete. If there was information from the first part of the interview that overlapped with the ASI questions, the ASI questions were not asked.

In order to reduce barriers to participation in the study, a choice of interview locations were offered, as well as varied hours or days. Each participant that completed the interview received a ($20) grocery coupon; for females with children the cost of child care and arrangements for child care were offered, but was never used. Snowball sampling was not used, but was made possible by detailing recruitment information for dissemination among participant's friends and the outreach staff at the participating

facilities.

All interviews were tape recorded, and the interviewer kept field notes immediately after each interview. All participants were guaranteed anonymity and all tape recorded information was kept confidential. No addresses or names were included in the interview, and the tape-recorded information was transcribed and only a code number was transferred to the interview sheets. Each participant was made aware through the information sheet and consent forms that they were allowed to discontinue participation in the interview at any time, and that it would not jeopardize their access to health services. However, no participants requested to stop and all completed the interview. All interview tapes were destroyed when the study was finished and only researchers involved in this study had access to the project information.

Data Analysis

Overview

Prior to starting analyses of the data, the original research questions guiding the study were revisited. A return to the initial research questions was imperative in order to develop themes for the transcribed interviews. The first goal was to gain an understanding of the history and present use of alcohol and/or illicit drug use along with respondent's social history and social supports. The second goal was to determine whether the substance using homeless respondents utilized the formal health care system and if there were barriers to using the services. The final goal was to explore social comparison processes in the sample by determining whether or not respondents

perceived that their own health was better or worse than others around them.

In light of these research questions, the goals of the analysis were to: 1) provide a general description of the participants with regard to basic socio-demographics, substance use, homelessness, and social characteristics, 2) transform the raw data from each of the interviews into thematic categories reflecting each research question, and 3) compare thematic categories between participants in order to identify common and perhaps invariant features for the sample. Analyses of the raw data including field notes, observations, and transcriptions was also meant to identify any overarching themes that may not have been initially identified through the research questions.

Data Sources and Consolidation

Five documents were generated from every interview: 1) a completed Addiction Severity Index (ASI - see appendix 6 for a copy), 2) an interview transcript, 3) a field note, 4) a thematic categories and observations document, and 5) a summary. Field notes, transcripts and ASIs were generated from the interviews themselves. Thematic categories and summaries were formed after analyzing the field notes, transcripts, and ASIs.

Addiction Severity Index. The information gathered from the transcript ASI and the written ASI focused on descriptive and demographic characteristics of each interviewee and of the group as a whole. The ASI information used to describe this population included 13 variables: age, sex, race, site of interview, HIV/Hepatitis C status, duration of time homeless (in months),

marital status, duration of time imprisoned (in months), present employment, number of children they had, age of onset for alcohol use, rate of alcohol use in past 30 days, rate of drug use in past 30 days, and number of times in detox or treatment for alcohol and drug use.

Information from the ASI was both recorded on audiotape and recorded in writing by the interviewer. Information from each transcript was read over two times; the first time to get a general feel for each interview and to get an overall idea of the content. A second reading identified specific information from the ASI, and this information was identified and recorded. ASI responses that provided descriptive information regarding homelessness, substance use, social characteristics of respondents, and general demographic information were identified and recorded separately. Information from the written ASI was compared to the information recorded in the transcripts to ensure that the written information was correct and to ensure completeness and consistency in the interviewer's written record of the ASI (i.e. triangulation of data sources).

Transcripts. An independent transcriber used a transcription machine and a word processor to translate audiotaped interviews into a written transcript. Emphasis was placed on the content of the interview and therefore pauses in speech or inflections in tone were not documented; however, the field notes accompanying each interview did contain some information regarding the paralinguistics of each interview, (e.g. if an individual responded with enthusiasm, or if speech was slurred or quiet).

Each interview was between 45 and 70 minutes in length. Every line of the transcription was numbered sequentially (to the left of each line) for ease of reference. To facilitate analyses, the researcher used a referencing system where the first number indicated the participant transcript number, followed by the numbers for the appropriate lines from the transcript. For example the reference (7:317-323) refers to participant and transcript #7, lines 317-323. This allowed for quoted text to be easily located within the original transcript. A specific software program was not utilized.

Field Notes. The researcher also wrote a field note following each interview, in which initial impressions, observations, reminders for follow up questions and inconsistencies in responses, verses observations of participants were recorded.

Developing Thematic Categories

In order to develop thematic categories related to the research questions guiding the study, each interview was read three separate times. From these readings, patterns of responses to each research question were identified that were similar across more than one interview. According to Boyatzis (1998) "The perception of this pattern begins the process of thematic analysis" (pg. 3). As well, Boyatzis (1998) states that seeing patterns across participants allows the data analyst to continue on towards classifying those patterns into themes. Once patterns were classified they were assigned labels and a description of transcribed material serving as indicators for the observed (Boyatzis, 1998). Interpretation of these

patterns in turn leads to the development of a theme or a group of themes, (Boyatzis, 1998).

In this analysis, the first reading of each transcript was designed to obtain an overview for each interview; the second reading identified patterns (i.e., text units) that occurred across more than one participant; and the third reading assisted in classifying these patterns, defining the patterns, identifying indicators for the patterns, and constructing thematic labels for each pattern.

Themes that related to the initial research questions were identified from each interview and compared across participants to determine if they were common to most or all of the interviews. Indicator words or indicating statements were identified for each interview in order to link themes to original transcript material. A definition was written for each theme in order to facilitate identification in subsequent transcripts. Finally, a label was given to separate and name each theme. Table 2 provides an example of one thematic category generated through this process.

Table 2: Example of a Theme

Theme #1	
Label-	Positive perception of own health
Definition-	The participant thinks that their health status is good, that they are healthy
Indicators -	Participant mentions a positive or affirming statement about their health, agree that they are healthy
Examples -	I: "Do you feel that you're in pretty good health?" R: "Right now, yes"

Between Participant Analysis

Once thematic categories were identified and described, the next step of the analysis involved systematically comparing transcripts to determine whether themes were shared across participants in the study. A variant of the constant comparative method was used (Glaser & Strauss, 1967), according to which each transcript was systematically compared with every other transcript within the sample, in order to determine the extent to which themes were found in more than one respondent's interview (Wild & Kuiken, 1992).

There were two goals of the between participant analysis. First, by systematically comparing transcripts across participants, new themes or sub-themes were identified. Second, the process allowed for the identification of themes shared by 2 or more participants in the sample. Where an interview contained text that was captured by a theme, a "1" was scored; otherwise "0" was scored, in order to describe the presence or absence of each theme for each participant (Wild & Kuiken, 1992). Table 3 provides an example.

Table 3: Coding Between-Participant Themes

	Theme #1	Theme #2	Theme #3
Interview #1	0	1	1
Interview #2	1	1	0
Interview #3	1	1	0

In this example, participants 1,2 & 3 all provided text relating to theme #2; however, participant #1 did not provide any information that related to theme #1 whereas participants 2&3 did. Participant #1 did provide statements regarding theme #3 whereas participants 2 & 3 did not. From this comparative information, trends in behaviours, beliefs, and issues were identified that occurred in all, many, or a minority of the interviews.

Summary

Once themes were identified, labeled, and defined across interviews, a summary paragraph of general impressions was written for each participant that reflected the transcript, ASI information, field notes and identified themes. The summaries included observations, homelessness issues, incongruencies within individual statements, or between statements and interviewer observation.

Chapter 3

Results

Description of the Sample

Information obtained from the ASI is displayed in Table 4 which provides each participant's age, sex, race, site of interview, length of time homeless (in months), marital status, length of time in prison (in months), and number of children. A total of 9 (69%) of those interviewed were male and 4 (31%) were female; 3 (23%) were Caucasian, 3 (23%) identified themselves as Metis, and 7 (54%) identified themselves as Native. With regard to study recruitment, 4 (31%) participants were recruited from the Royal Alexandra hospital emergency or in-patient department, while 9 (69%) were recruited from the George Spady Centre. Of the 13 interviewees, 7 (53.8%) considered themselves to be in a common-law relationship, while 6 (46.2%) considered themselves single or separated.

Table 5 presents data on the age of first alcohol use, rate of alcohol and drug use in the past 30 days, HIV status, Hepatitis C status, and the number of times in detox or treatment for alcohol or drug use. All (13) of the individuals interviewed drank alcohol to excess within the past 30 days, while 84.6% (n=11) reported drinking to excess daily, and 15.4% (n=2) reported periodic binge drinking patterns. With regard to drug use in the past 30 days, Table 5 indicates that 5 of those interviewed (38.5%) stated that they have used some form of illegal drugs in the past 30 days, with

Table 4. Demographic Characteristics of the Sample

Interview	Age	Sex	Race	Site	Marital	Homeless	Prison	#Child
#1	47	M	Metis	Rah	Com-law	84	84	0
#2	46	M	Caucasian	Rah	Single	360	240	1
#3	31	M	Caucasian	GS	Single	120	0	0
#4	44	M	Caucasian	GS	Single	8	5	0
#5	40	M	Native	GS	Com-law	24	.33	0
#6	34	M	Metis	GS	Com-law	6	36	3
#7	35	M	Native	GS	Com-law	3	2	0
#8	45	M	Native	GS	Single	36	240	2
#9	48	F	Native	GS	Single	96	0	3
#10	43	F	Native	GS	Com-law	36	8	3
#11	38	F	Native	GS	Com-law	96	6	6
#12	46	M	Native	Rah	Com-law	36	144	2
#13	38	F	Metis	Rah	Separate	240	0	2

M=male, F=female, Site = Sample Site, Rah=Royal Alexandra hospital, GS= George Spady Centre,marital=marital status, Com-law=common-law, homeless=months homeless, prison=months spent in prison, children=# of children

3 (23.1%) individuals using daily and 2 (15.4%) individuals using only occasionally.

Table 5 also indicates that there were only 2 out of the 13 participants who reported or knew that they were HIV positive (15% of respondents), while 4 of the 13 reported or knew that they were Hepatitis C positive (31% of respondents).

Table 6 presents summary descriptive statistics for the five continuous demographic variables, including: age, length of time homeless (in months), number of children, length of time in prison (in months), earliest onset of alcohol use, and the number of times

Table 5: Health-related Demographic Characteristics

Interview	Age etoh	Rate of etoh	Rate of drug use	HIV	Hep C	Treatment
#1	18	Daily	Daily	No	No	18
#2	8	Binge	No	No	No	100
#3	12	Daily	Daily	No	No	2
#4	16	Daily	No	No	Yes	2
#5	14	Binge	No	No	No	4
#6	15	Daily	Occasional	No	No	5
#7	13	Daily	Occasional	No	No	12
#8	4	Daily	Daily	Yes	Yes	30
#9	28	Daily	No	Yes	Yes	3
#10	15	Daily	No	No	No	15
#11	9	Daily	No	No	No	90
#12	13	Daily	No	No	Yes	3
#13	16	Daily	No	No	No	3

Age etoh= initial age of drinking alcohol, rate etoh. =rate of alcohol use, drug rate=rate of drug use, HIV= HIV status, Hep C= hepatitis C status, Treatment=number of times in treatment for alcohol or drug use.

in detox or treatment. Table 6 shows, the average age of study participants was 41.15 years (S.D.=5.54) with ages ranging between 31 and 48 years. The number of children that these individuals have ranged between 0 and 5, with the average number being 1.69 (S.D.=1.62). The average length of time that respondents were homeless was 88 months, ranging from 3 to 360 months (S.D.=104.4 months). The range of time spent in prison was 0 to 240 months, with the average being 58 months (S.D.=91.0 months). The earliest reported onset of alcohol use was 4 years old and the latest onset was 28 years old, with the average being 13.9

years of age (S.D.=5.69 years). Finally, the number of times that participants spent in detox or treatment for their alcohol and/or drug use ranged from 2 times to 100 times, with the average being 22 times (S.D.=33.46 times). These figures would include episodes of attendance at the George Spady Centre.

Table 6: Continuous Demographic Data for the Sample

	Minimum	Maximum	Mean	Std. Dev.
Age	31.0	48.0	41.15	5.54
Homeless	4.0	360.0	88.08	104.41
Prison	0.0	240.0	58.91	91.03
Children	0.0	6.0	1.69	1.62
Etoh age	4.0	28.0	13.92	5.69
Treatment	2.0	100.0	22	33.46

Homeless =# months without permanent residence, prison =months spent in prison, children =# children, etoh age = earliest age of alcohol use.

When separating demographic data for males and females, Table 7 demonstrates that all of the women participating had children, all of the women were native or Metis, all of them had significant periods of time homeless (75.2 months), most were in a relationship of some kind (75%), none of them used drugs and alcohol together, they had lower levels of jail time (3.5 months) and they started their alcohol use at an older age (17). Table 7 indicates that in comparison with females in the sample, males responding had experienced longer lengths of time in jail (83.5 months verses 3.5 months) and being homeless (117 months), had a more varied racial make-up (33% Caucasian vs. 100% Aboriginal), were less

likely to have children (66% vs. 100%), were using drugs and alcohol more often at the same time (55% vs. 0%), and tended to start drinking at an earlier age (12.6 years old vs. 17 years old).

Table 7: Sex Differentiation of Demographic Variables

	Males n=9	Females n=4
Children	66% (n=6)	100% (n=4)
Race	66% native (n=6)	100% (n=4)
Homeless	117 months (S.D.= 121.5)	75.2 months (S.D.= 99.26)
Prison	83.5 months (S.D. = 100.99)	3.5 months (S.D.= 4.12)
Etoh age	12.6 years (S.D.= 4.25)	17 years (S.D.= 7.96)
Etoh & drugs	55% (n=5)	0% (n=0)
Marital	55% (n=5)	75% (n=3)

Homeless =average # months homeless, prison = average months in prison, etoh age = average age of initial onset of drinking, etoh & drugs = percentage of individuals who use both together, marital =percentage of individuals who consider themselves part of a marital relationship.

Among the 13 participants, 9 (69%) identified having some social and early parental or family problems. Out of these 9, 5 (50%) were brought up in a foster home or raised in a boarding school, and 5 (50%) were physically, sexually and/or emotionally abused by either their parent, foster parent, or close relative. There was a large variance within length of time homeless for both men and women, and with length of prison terms for men.

Themes

Themes were identified across all 13 interviews using the analysis procedure described in the previous chapter. Indicators that allowed one to determine if a specific theme was present were also listed. The first 5 themes revealed through analysis do not

directly relate to the initial research questions; however, they were very salient across participants and thus provide insights and possible connections between themes and the initial research questions. Therefore, these first five themes are included in the results as they are relevant and important when discussing this population and could not be excluded.

Causes of Homelessness. The first theme related to how each individual ended up in their present situation of homelessness. Table 8 identifies the label, definition and indicators comprising this theme.

Table 8: Perceived Causes of Homelessness

Theme #1	
Label-	Perceived causes of homelessness
Definition-	Identification of specific issues that led to being homeless
Indicators-	Loss of work, social stressors, alcohol or drug use, conscious choice to live without a permanent home

There were a number of different issues or situations that respondents indicated propelled them into homelessness. These statements were grouped into two sub-themes. The first sub-theme (as described in Table 9) reflects the theme that homelessness was an active choice that they made on their own. One individual who indicated that homelessness was their choice stated: "I choose unstable, because it gets boring. I don't know. I like moving around" (2:603). Another indicated that "I left home when I was fifteen...I was staying at a women's shelter, and they called my name. I went downstairs, and my mom was there. She said, 'I'm here to take you home'. So I went with her. I lasted a month out there. It's a small

Table 9: Homelessness as a Choice

Theme #1a	
Label-	Homelessness as a choice
Definition-	Indication that the particular individuals made a conscious choice to live without a fixed home
Indicators-	Preference towards a nomadic lifestyle, preference to live outside of a stable environment

place where I come from, so I didn't like it, so I came back" (10:671-675).

A second sub-theme was common among respondents who indicated that their homeless situation was precipitated by adverse social situations and stressors, as seen in Table 10. One participant stated: "I had my own place, but I got in a situation where I was getting used (by roommates)...it's just, I didn't want to go home" (9:13-14). This same participant also reported that it was the

Table 10: Homelessness as a Result of Adverse Social Conditions

Theme #1b	
Label-	Homelessness as a result of adverse social conditions
Definition-	Identification of specific social events or situations that caused or precipitated homelessness
Indicators-	Loss of work, social stressors, alcohol or drug use, problems with family and/or friends

illness of her boyfriend and his present condition that got her started back drinking heavily and eventually homeless: "It's just a total shock, and I just said, "Oh I can't handle this." It kept going in my head. Came away from the hospital, and that's when I ended up here.... I just boozed the whole time till I got here" (9:180-181,183).

Other participants indicated that homelessness was because of a compilation of a number of factors including social stressors, alcohol use and job/financial loss: "things just started spinning in my head about the issues I've been trying to deal with (past sexual abuse), and I got pulled back into the bottle (ended up at the Spady Centre)" (4:13-15).

Barriers to escaping homelessness. Theme #2 relates to the participant's perceptions as to why they have been unable to escape their homeless situation. Table 11 outlines the general label, definition and indicators relating to this theme.

Table 11: Difficulties Escaping Homelessness

Theme 2	
Label-	Difficulties escaping homelessness
Definition-	Identification of issues individuals must face in being homeless and trying to escape it.
Indicators-	Financial difficulties, lack of social services support, inadequate living conditions of the low-income housing options, lack of shelters.

Within this broad theme there were also two sub categories that emerged. The first sub-category related to participants feeling that alcohol and/or drug use kept them from being able to get out of the homeless situation that they were in, as indicated in Table 12.

One participant reported that by starting with just one drink you get yourself into a situation where people won't want to talk to you, hire you or rent you a place to live, "and then you go for just one drink, and by one o'clock you can't change your situation, because who wants to speak to an individual that's drunk? Maybe not polluted where they're belligerent or anything, but just..."

Table 12: Drug or Alcohol Related Blocks to Escaping Homelessness

Theme(2a)	
Label-	Drug or alcohol related blocks to escaping homelessness
Definition-	Participants state that either alcohol or drugs are a major reason why they continue to remain homeless or have difficulty escaping homelessness
Indicators-	Indication that it's the pull of or the regular use of alcohol that prevents them from finding a place to live or from finding work

(7:307-309). This excerpt suggests that because of drinking one cannot begin to find work or a place to live because employers or property owners will not want to talk to a drunk individual. Another individual related his drug use and alcohol use as something that makes him happy and therefore why would he want to give up a lifestyle he enjoys: "When I die I might as well die with a smile" (8:153).

Many participants indicated that their inability to escape homelessness was due to a lack of financial or social support, as indicated in Table 13.

Some participants indicated that a lack of finances led to ongoing homelessness: "if you get a place to rent, the rent is the same as what welfare gives you (leaving nothing extra)" (11:591-592), or "the rents are so high, and then---you know, how are you supposed to afford some place to live?" (9:639-641). Others indicated that housing available to them with limited financial resources is inadequate: "and when you do find a place, it's like cockroach infested" (9:748-749), or "I don't find that the dwellings are adequate, because some will have bugs; and not only that, the

clientele that's in there, I don't need no hookers walking around with needles sticking out of their arms" (7:292-294).

Table 13: Financial and Social Support Related Blocks to Homelessness

Theme(2b)	
Label-	Financial and social support related blocks to escaping homelessness
Definition-	Participants report that they are unable to find an adequate place to live due to financial constraints or lack of support (financial and/or social), 'the system' supports and perpetuates homelessness.
Indicators-	Statements that reflect difficulties obtaining adequate financial support from the government to cover costs of housing, expense of a place to live, inability to find work secondary to lack of education or resources

Another participant similarly reported that low-income housing was inadequate: "I'm not going to live in dumps...This one place wanted me to sign a paper. A damage deposit for mice and cock roaches? Forget it!" (3:634-635). Participant #7 provided a more extended description of this issue as follows:

> "It's just that I noticed that since I've been down here, some people, they've been down here forever, and they just don't seem motivated, and they lack some of the social skills needed to get along in society like an average human being would without an alcohol or drug problem, which I think is unfortunate, because basically all they've learned is what they've seen" (7:199-203) and, "You just fall into a groove. Once you're there, it's hard to get out. If someone offered me a home, I'd say "great!" If social services would make it easier for an individual to obtain some financial benefits, it would be a lot easier" (7:750-752).

For some participants, the way that inner city shelters and programs are set up perpetuates the homelessness and the drinking: "I would go to the Bissel Centre and try and pull a number (to get work), but they told me that I had to register at one o'clock in the afternoon... the liquor store is so adjacent, and people go, 'hey come on, you look hungover'" (7:307-309). This participant believes that because the Bissel Centre (and thus their work opportunity) isn't open until later, that they have nothing to do until one o'clock, so until then they are constantly approached by other people in the same situation to start drinking while they wait. This same participant stated that "Some people I've noticed around here, they get exhausted because they're up at seven, six-thirty in the morning still drunk, intoxicated, stoned; and they have to leave, cold or not cold,... raining. And where do they go? They go and do all over again" (7:155-159). This statement reflects the practice of the shelters to have everyone up early and out whether or not they are ready, and that this propagates the continued use of alcohol and drugs, which in turn prevents these people from getting out of their homeless situation.

There were a few participants who indicated that living on the street was their choice, and do not have a desire to escape homelessness, "I choose unstable, because it gets boring...I like moving around" (2:603). For others, they do not feel a need to escape homelessness because it's where their friends and social supports exists, "I grew up with everybody here (on the street)...I consider them, all these people down here, my family, ... I know them a lot better than my own" (11:582-586).

Some participants described continued homelessness in relation to factors outside of their control and because of third parties such as the government or social services, or they indicated that it was their active choice and made no excuses for their situation. For example participant #7 and participant #9 both made statements indicating that a lack of affordable housing or inadequate financial assistance was why they were unable to escape homelessness, while participants #2 and #11 reported that they chose this lifestyle for its benefits of friendship and freedom.

Isolation from family members. Theme #3 reflects statements that indicated poor contact and/or lack of contact with personal family members, such as children, parents, or both. Many respondents reported that because they left home and live on the street, they do not see their family, and that the people and friends that they have on they street are now their family, as indicated in Table 14.

Table 14: Reduced Contact with Children and Parents

Theme #3	
Label-	Reduced contact with children and parents
Definition-	Statements in which participants indicated that their relationship with parents or children have diminished
Indicators-	Children not brought up by participant, participant unaware of parents or children's location, minimal physical or verbal contact.

Within this theme two sub-themes arose, the first related to a general decline in contact with family and the second related to little to no actual knowledge of family. Table 15 describes the label, definition and indicators of theme 3a.

Table 15: Reduced Contact with Family

Theme #3a	
Label-	Reduced contact with family
Definition-	Indication that participant's relationship with their biological family has declined.
Indicators-	Statements reflecting reduced or limited contact with parents, siblings or children

One individual stated that "my family and I are not close at all...I've never seen my parents for years. I don't know where my mother is....my kids I see once in awhile, not too often" (1:502, 518, 526). One individual reported that "-because I grew up with everybody here. I don't even really know my family...I consider them, all these people down here, my family, more my family than- I know them a lot better than my own" (11:582, 585-586). Another participant stated that she never knew her parents well as she grew up in boarding schools, "basically anything about my family is hearsay, because most of my life was spent in boarding schools...I knew who my mom was, but I didn't grow up with her" (9:577-579). Another grew up in foster care: "they had to put us in foster homes because my mom and dad had separated, and my mom couldn't support all of us" (12:709-710).

Another individual indicated that he knew he has family but was unsure where they were: "I got grandkids too. My daughter left, I think, two. Yes, when she died she had two already. But I think they're with their grandma" (3:701-702). Participant 7 reported that his lack of contact with his children bothered him and that he wanted to improve their relationship: "It kind of bothers me for the

simple fact as I miss out on some of the greatest moments of his life and my own. But that maybe might not last for long" (7:701-702). Another participant reported that her reduced contact with her children was difficult on her kids: "See, my son misses me. I talked to him the other day, and he'll say. "Mom, when are you going to come home?" (10:549-560), but later said "Oh, it's my fault (that I don't see my son) because I could go back there" (10:585) which suggests that it was her choice to reduce her contact with her family.

One participant reflected on his poor family situation as follows: "My father used to beat my mother up all the time, and I told him when I turned fourteen and got big enough, I was going to give him a licking, and I did. And my mother finally left him." (1:540-541).

Theme 3b (as described in Table 16) reflects the idea that respondents did not know their biological family at all. One individual, when asked if he had children, responded: "I think I got two, I *think*, okay? Can't say for sure, because one time this girl come downtown: "R-----, you got a little boy now, you know" (8:676-677).

Table 16:No Knowledge of Biological Family

Theme #3b	
Label-	No knowledge of biological family
Definition-	Indications that participant does not know or never knew his/her biological family
Indicators-	Statements regarding no contact or knowledge of parents, children or siblings

Another individual stated that " I never met my father....I'm aware I have two real sisters" (7:571, 589). Another individual stated "I don't even talk to him (dad) either because I don't get along with my mom because she took me away from my dad and didn't even bother to take my twin brother. And then my dad never did know me" (11:620-622). This participant also indicates that she does not know her children: "My kids, I don't know how I can get a hold of them...they don't allow me to (see my kids). My mom just gets pictures" (11:634, 636).

Family history of substance abuse. Theme #4 relates to a collection of statements that indicate a family history or ongoing misuse of alcohol and/or drugs, as shown in Table 17.

Table 17: Family History of Alcohol or Drug Abuse

Theme #4	
Label-	Family history of alcohol or drug abuse
Definition-	Participants indicate that members of their family had or continue to have alcohol or drug use problems.
Indicators-	Statements regarding parental or sibling use of alcohol on a regular or ongoing basis.

Many respondents indicated that either their parents, grandparents or siblings also misused alcohol or drugs, others related that their whole family has had alcohol and/or drug issues. One participant reported that alcohol was an issue for her entire family: "Alcoholism took over. Alcohol's always been a big part of my family, because my mom was an alcoholic, my brothers and sisters. I grew up around alcohol" (9:344-345). Other participants indicated that the influence of alcohol occurred at a young age: "he was a drunk (my dad)....I remember I drank with him, okay? Up in

Yellowknife when I was twelve years old" (8:612-613). Some indicated that misuse of alcohol and drugs within their family resulted in death: "They're all drinkers too (my brothers and sisters), what's left of them. Most died from drug overdosing" (12:590). Another participated described his brother as follows: "he used to be a speed freak" (1:453), and his father as having problems with "alcohol" (1:457). Similarly, participant 3, when talking about his brother, stated: "heroin, he was doing heroin, and I never knew he did" (3:602) and participant 11 stated that with regards to drinking "my twin brother. I think he's worse than me" (911:543). When asked if anyone in his family had a problem with alcohol respondent 4 stated: "my father, my brother, my sister. She's also got a drug problem" (4:388, 390). Each of these statements reflects that alcohol and/or drugs not only play an important role in the lives of the participants but also in the lives of their family, past and present.

Facilitators of continued substance abuse. Theme #5 refers to statements reflecting positive social supports for continuing alcohol or substance use. Table 18 provides the label, definition and indicators for this theme.

Two sub-themes emerged, the first one is a positive structured environment that supports and propagates substance use among the homeless, as described in Table 19.

Table 18: Positive Social Support Towards Continuation of Substance Abuse

Theme #5	
Label-	Positive social support towards continuation of substance abuse
Definition-	Participants relate that through the influence of friends there is a re-enforcement towards the continuation to drink or use drugs.
Indicators-	The number and closeness of certain family and friends and how they too use alcohol and drugs on a regular basis, they all hang out together, drink or use together, panhandle for money together to buy more, and how they share the money and the drugs among them.

Table 19: Structured Environmental Support for Ongoing Substance Use

Theme #5a	
Label-	Structured environmental support for ongoing substance use
Definition-	Indications that the homeless environment and formal structure propagates and encourages the ongoing use of substances
Indicators-	Statements reflecting that the set up of shelters and support services to the homeless actually encourages use of substances

Positive support may involve needing a place to sleep at night and knowing that the only way one can access this particular shelter is if you're intoxicated: "I drink everyday just so I can get into the Spady Centre. You can't get in if you're not drinking" (8:207-208). Another participant stated: "the liquor store is adjacent (to the Bissel Centre), and so people go, "hey you look

hungover". And then you go for a drink, and by one o'clock you can't assess your situation, because who wants to speak to an individual that's drunk?" (7:304-308). The last statement is reflective of this theme because when the individual was describing the situation, the lead in statement to start drinking on a 'new' day was "you look hungover.... (So why don't you join us to drink?)". It almost appears that individuals are supported and encouraged to continue drinking by the whole inner city, homeless lifestyle that they're faced with daily.

The second sub-theme reflects positive support of friends and/or family towards ongoing alcohol and/or drug use, as described in Table 20.

Table 20: Positive Family/Friend Support Towards Continued Substance Use

Theme 5b	
Label-	Positive family/friend support towards continued substance use
Definition-	Indications that friends or family provide positive reinforcement towards substance use
Indicators-	Closeness of family and friends and their use of various substances, drinking together, hanging out together, getting money together to buy substances, sharing of substances among them.

Some indicated that friends who also drink pay a pivotal role: "because they (my friends) drink as much as I do. That's all we live for. That's all we go bottle picking for, is to make enough to drink" (1:561-562) or "And all your friends are kind of there, and they're all doing the same thing (drinking)" (12:476). Other participants

state the support they receive from friends for drinking more subtly: "I don't spend money (on alcohol). It's my friends" (10:395); "I know people who say, "here I owe you from when you bought me a drink before", and that" (11:443).

These last three statements suggest that the people who respondents spend time with and hang around continuously support and abet alcohol abuse. An example of a typical daily pattern of the participants is as follows:

"I wake up in the morning about six-thirty or twenty to seven, and then they kick us out (of the George Spady Centre) about seven o'clock, quarter after seven...and then I go down and I usually have a bottle stashed somewhere, so I pick up my bottle...and then I wait till the liquor store opens...I might go downtown. I do hustling, go panhandling...I've to be (back) at the Spady on time or I won't get in there" (12:177-189).

Another good example of the typical day that these individuals face is as follows:

"I get lonely, depressed...It's so early they kick you out of here... and It's cold out there...you got no place to go...So what do I do? I go to the Bissel, sit around, drink coffee, wait till the liquor store opens, and then go drink" (10:236-243).

Perceptions of health. The next 5 themes were identified in response to the initial research questions. The sixth theme identified was that of a positive perception of own or self -health (Table 21).

There were two obvious and definite sub-themes, which were either a positive affirmation that they perceived themselves as healthy or a positive no that they did not perceive themselves as healthy. A third theme was a qualified affirmative response. Theme 6a, as described in Table 22, indicated positive responses.

Table 21: Positive Perception of Own Health

Theme #6	
Label-	Positive perception of own health
Definition-	The participant thinks that their health is good, that they are healthy
Indicators-	Participant mentions a positive or affirming statement about their health, agree that they are healthy.

Table 22: Positive Affirmation of Perception of Own Health

Theme #6a	
Label-	Positive affirmation of perception of own health
Definition-	Indications that participants generally felt that their health was good
Indicators-	Statements reflecting a positive or affirmative perception of their own health

Typical responses to the question, "Do you consider yourself healthy" were short and direct. Some examples include:

> "Consider it? Yes, fairly" (9:107).
> "Generally, most of the time" (7:86)..."because I consider myself pretty generally okay" (7:244).
> "Oh yes, just not when I'm hungover" (3:181).
> "Right now, yes" (1:64)
> "Yes, what I miss most is exercising (when in hospital)...A guy came and told me, "is your stomach naturally hard like that?' I says, "yes, sir. I do sit-ups"(2:85-88).

These statements all reflect that these individuals perceived that their health was fairly good.

Table 23 reflects theme #6b, where participants had a negative response to their perceived health.

Table 23: Negative Perception of Own Health

Theme 6b	
Label-	Negative perception of own health
Definition-	Indication that participants did not feel that their health was good
Indicators-	Statements reflecting why they felt their health was poor

Respondents who indicated that they felt that their health was not good offered more detailed responses to the interview questions. Some examples of those individuals who did not perceive their health as good include:

> "No, because of the asthma, diabetes and all these pains when the weather changes" (11: 163-166).
> "I used to, but not right now (I'm in the hospital)" (12: 24).
> "No, with my alcohol abuse and having Hep C, my condition has deteriorated in the last 3 months" (4:28-31).

The final sub-theme, as described in Table 24, reflects individuals who perceived that their health was good but only under certain circumstances.

Table 24: Qualified Positive Perception of Own Health

Theme #6c	
Label -	Qualified positive perception of own health
Definition-	Indications that participant felt their health was good most of the time, but not in specific circumstances
Indicators-	Statements reflecting that they felt okay unless they were drinking or hungover

Individuals who needed to qualify their positive perception of their own health indicated that it was the effects or use of substances that made them feel that their health was poor. There were a few respondents that qualified their statements with "just not when I'm

hungover" (3:181) or "Generally, most of the time....not when I'm consuming alcohol" (7:86-88).

Social comparisons and perceived health states. Theme #7, as described in Table 25, relates more specifically to whether or not individuals felt that they were healthy compared to the other people around them or the people that they spend most of their time with.

Table 25: Positive Social Comparison of Health

Theme #7	
Label -	Positive social comparison of health
Definition-	Participant feels that their health is better than the health of the people around them
Indicators-	Positive or affirming statements that their health is better than that of their friends or family

Some responses were very concise and others were more elaborate when they were asked "Do you consider yourself more or less healthy than the people you hang around with?". Examples of these responses include:

> "Yes, I think so, part of it, I think, hygienic wise...that's always played an important role in my life" (9:112-113).
> "Yes, actually, because guys my age, I don't know, they're not active....they're mentally unhealthy,...they blame everything and everybody, but don't look at themselves" (2:100-102).
> "I see a lot people worse than me" (10: 118).
> "I've seen people maybe a hundred and twelve pounds who used to be way bigger than me...HIV" (8:146-147).

The statement above from participant 8 indicated that although he has HIV he feels that he is still healthier than other people he knows with the same condition. Some individuals

perceived that their own health was poor but indicated that they still felt that it was better than the health of others around them. For example, one respondent answered the question about comparing his own health with others as follows: "No, with my alcohol abuse and having Hep C, my condition has deteriorated in the last 3 months" (4:28-31) and "No, I'm healthier than they are. I just know what position I'm in right now where I've hit bottom where I've malnutritioned myself" (4:72-73). The one individual who did not perceive that her health was better than those around her stated "I'm less healthy, they don't have diabetes and they don't have asthma" (11:171-172). This statement qualified why she felt that others were healthier than she was; however, upon observation, this individual appeared in fairly good physical health compared to the other interviewees.

Participants also identified what they perceived as unhealthy with regard to their peers: "people down on the street. I know some friends, they sniff, some of them lose their lungs" (10:122-123), or "not being able to walk around as I used to" (2:720-721). These statements indicated that having difficulty breathing or an inability to ambulate on one's own, were indications of poor health as perceived by the participants. In the next results section, in Table 35, there is a summary of between participant analysis where the total number of positive and negative responses to this question is presented. It is important to note the variability of definitions of health among the participants. Some related health to the absence of disease, others to declining function.

Incongruencies between stated and observed health. Another theme identified through analysis was incongruencies between stated and observed health indicators. The label, definition and indicators of this theme are displayed in Table 26.

Table 26: Incongruent Health Indicators

Theme 8	
Label-	Incongruent health indicators
Definition-	Where participants demonstrated incongruent statements concerning their perception of their own health with their actual health issues.
Indicators-	Identification as themselves as healthy compared to others, yet also indicates serious acute or chronic medical problems.

Most of the respondents who considered themselves healthy or healthier than the people they spend time with still had significant medical issues. Many of the participants had a positive response to the question of whether or not they perceived that their health was good in relation to others. For example participant #1 responded "right now yes" (1:64) when asked if he felt that he was healthy yet went on to explain his physical illnesses and injuries,

> '"I've got tissue between the vertebrae; it's pinched. I fell off an oil rig" (1:38) and "my stomach, an ulcer operation...I've only got half a stomach left, plus they took my gallstones out" (1:70-71).

The participant also mentioned that he was diabetic, asthmatic and has been hospitalized for respiratory failure.

Interviewee #2 presented a similar response, for example he stated "Yes, what I miss most is exercising...the guy came and told me, "Is your stomach naturally hard like that?" I says, "Yes, sir. I

do sit-ups" (2:85-88) when asked if he perceived himself as healthy, but responded later "I've been too busy not being able to walk around as I used to" (2:720-721) and "I had a big piece of glass in my head...and it cracked my skull a bit" (2:116,135). This participant also had a previous head injury; poor hearing in one ear secondary to a fall, has had previous fractured ribs, and was stabbed. On observation, he had an extremely ataxic gait (poor balance, wide base of support), was unable to walk independently due to dizziness and poor balance, and had moderate atrophy of his left arm and leg.

A third example of this theme came from interviewee 9, where she stated "Consider it, yes, fairly" (9:107), and "hygienic wise, I know I am, because that's always played an important role in my life" (9:112-113) in response to the questions "do you consider yourself healthy" (9:106) and " do you think you're healthier than them (the people you hang around with)" (9:110-111) respectively. However, this same participant had earlier stated that she was HIV and Hepatitis C positive, had a heart and kidney condition "they kept me for observation of my heart...and my kidneys" (9:64). Another respondent initially stated that he felt his health was generally good and better than that of his peers: "Generally, most of the time (I'm in good health)...I would say (my health) is better, because I've seen some people that were worse". However, this same participant described his medical history by including: "more than ten hospitalizations ...that hand infection I had. I had a couple of head injuries...I had my jaw broken in February" (7:49, 59, 62). One participant indicated that: "I'm healthier than they are (my

peers)" (4:72), but went on to describe his medical history: "with my alcohol abuse and having Hep C, my condition has deteriorated in the last three months...I've had to go through three knee surgeries to rebuild my knee (after being shot)" (4:31-32, 44).

Participant 3 also reported a positive response to his own perceived healthiness: "Oh, yes (I feel I'm in pretty good health overall)" (3:181). However, this same participant relayed to the interviewer episodes of multiple traumas and hospitalizations: "I was in the hospital last week for my ankle...he (the doctor) says I have arthritis in there now... it won't go away" (93:26-29). This individual related that he had an old ankle fracture with a pin repair, had a fractured nose and ribs and a severed finger; as well, on observation, his speech was severely slurred and had multiple scars on his face, limped quite severely and used a cane.

One other participant also reported that he felt his health was better than those around him by comparing himself to other IV drug users: "I've seen people (other IV drug users) with maybe a hundred and twelve pounds. They used to be way bigger than me...they'd rather do drugs than eat" (8:146-149). This individual still feels that he is healthier because he's not as thin; however, he indicated that he has multiple medical issues: "I've OD'd so many times, I don't have a clue...Got hit by a car...fell down from the top floor (at Edmonton Centre shopping mall)...(I'm) HIV, Hep C" (8:32,42,44,128). These individuals all describe quite serious and functionally impairing medical issues but still feel that overall their health is better than that of their peers. One thing that needs to be

remembered is the age of these individuals, with an average age of 41 years old; these people have numerous illnesses and injuries.

There were two individuals who perceived that their health was good, and there were no statements or observations to contradict these perceptions. These individuals made statements that were congruent with their observed and stated medical status

Use of health services. Theme #9 classified pattern statements indicating that many of these participants use formal health care services only for immediate medical emergencies rather than for preventive care or monitoring of medical issues.

Table 27: Reasons for Using Health Services

Theme #9:	
Label-	Reasons for using health services
Definition-	Participants only use health services for emergencies/immediate problems, not on a regular basis or for prevention/check-ups.
Indicators-	Individuals identify their health care use for emergencies, to treat specific problems only, for life and death situations, are forced to use services as they are too ill/injured to decline, or for pharmaceutical needs only.

Within this theme three separate sub-themes emerged. The first sub-theme identified was that of using health services only for dire emergencies, as described in Table 28.

One participant related his rationale for using formal health care services by stating that:

> "the only reason I came in this time was because the Spady (George Spady Centre) called an ambulance...I swallowed twenty T3's, and I was drinking at the same time, and I went

to have a shower, and as soon as the warm water hit me, I collapsed and hit the floor" (1:132-135).

Table 28: Medical Services for Emergencies Only

Theme #9a	
Label-	Medical services for emergencies only
Definition-	Indications that participants only felt that health services were for life and death emergencies
Indicators-	Statements reflecting that individuals only used health care services when taken by others, when unconscious and unable to refuse.

This same individual later indicated that he came into hospital recently because "Spady brought me because I had to because I was comatose" (1:356). Another individual responded to the question about regular use of doctors for check-ups by stating:

> "it's not that I don't believe in doctors; I believe in doctors. But it's just, I see too many young guys or even guys my age ...malinger or want self pity" (2:146-148).

This participant evidently believed that individuals who regularly go to see a doctor are not going for health reasons but rather for attention seeking. This same participant stated that the only time he'll go to the doctor or hospital is "when I'm unconscious" (2:150) such that "if I had to go see a doctor in the hospital on my own, then I don't have to go" (2:156-157). Other participants shared similar beliefs and practices responding that they go to the hospital or doctor, "only when I have to" (12:139) and indicated that on this hospital admission "somebody made me go" (12:146) or "I had to go in...I couldn't walk" (3:100,104).

The second sub-theme reflects individuals who will use their regular general practitioner for ongoing check-ups for chronic illnesses, but still only go to the hospital when forced. Table 29 describes this theme.

Table 29: Medical Services for Check-ups, Hospitals Only for Dire Emergencies

Theme #9b	
Label-	Medical services for check-ups, hospitals only for dire emergencies
Definition-	Indications that participants will go for regular check-ups with general practitioners if they have chronic illness, but will not access emergency or hospital services unless it is a life and death emergency.
Indicators-	Positive use of health clinics and non-emergent community services to deal with ongoing medical issues, but negative use of hospital services even when warranted, an ongoing dislike for using hospitals.

Two participants indicated that they do have a regular doctor that they see to help manage chronic illnesses, but when they are becoming acutely ill need to be encouraged or forced to go seek treatment. For example in response to seeing a doctor regularly, the individual responded with "yes I do, I go at least once a month" (1:88), but when asked about going to the hospital responded " I always wait until the last minute...I just don't like hospitals...I don't know why" (1:98,102). Another participant initially stated "I have a family doctor... (I see him) once a month" (11:174-176), but earlier had stated "If you take me to that butcher shop (hospital), I'm going to walk out" (11:77-78). This participant obviously had a

negative perception of the acute care hospital, and did not have any desire to return or go there.

The third sub-theme was that of using health care services for pharmaceutical means only, as described in Table 30.

Table 30: Medical Services for Pharmaceutical Means Only

Theme #9c	
Label-	Medical services for pharmaceutical means only
Definition-	Participants feel that their only need out of health care services is to obtain medications and drugs
Indicators-	Statements reflecting need to get drugs to manage chronic illnesses or drugs for recreational use or financial support

Many of these individuals don't think of the doctors office or the hospital as a treatment or preventative health care service, but only as a pharmaceutical dispensary: "(I go to the doctor) just when I need my medication... I just go there (the doctor) to pick up my Dilantin and my puffer" (10:172,214). Another participant stated that: " once a month (I go to the doctor), when I need my medication" (11:177), and "if I see a doctor and I get no drugs, I don't see that doctor again" (8:221). Another participant maintained that he knows a number of peers that perceive doctors as pharmaceutical dispensaries: "I have friends that go there (doctor) to scam the doctor ...to sell pills" (12:197, 209).

Barriers to accessing health services. Others indicated that health care was for emergency use due to difficulties in accessing and using preventative health care services when one is homeless. Most of these issues are covered under theme #10, which identifies barriers to health care service usage. Table 31 describes the label,

definition and indicators relating to theme #10 and the perceived barriers to accessing health care services. There were 3 sub-themes identified within this one theme.

Table 31: Barriers to Using Health Services

Theme #10	
Label-	Barriers to using health care services
Definition-	Participants identified barriers to using hospitals and clinics
Indicators-	waiting lines, poor treatment, over crowding, racism, judgmental, medical mismanagement, and health care as not a priority as they need to focus on shelter and food.

The first sub-theme reflects barriers to using the health care services as a result of prolonged waiting periods, as described in Table 32. A number of individuals indicated that the waiting time to see a health care professional was too long. When asked why they

Table 32: Prolonged Waiting as a Barrier to Health services

Theme #10a	
Label-	Prolonged waiting periods before seeing a health professional.
Definition-	Participants indicate that waiting lines and reduced staff numbers are a barrier to using formal health services
Indicators-	Statements reflecting waiting lines, prolonged time spent in reception areas and waiting rooms, poorly staffed facilities with inadequate staff to see everyone in a timely manner.

don't like to see a doctor or go to the hospital some of the responses were, "because you got to wait so long to get in there" (10:142), or "...the long line ups" (9:235). Some individuals responded to the question of how could the services of the health care system be improved, with, "they could speed up the process" (12:169), "if

they had more doctors" (11:211), and " a little bit faster service, instead of waiting 5 hours to get an x-ray" (9:233). Another individual stated that: "it takes so long to see them (doctors), and I heard this one guy died there from waiting, from waiting to go in" (10:206-207). These individuals again believe that time is an issue in accessing and using the health care services, that they want and expect emergent care.

The second sub-theme was that participants felt that judgmental or condescending staff was a barrier to using health care services. Table 33 describes this theme. Some individuals indicated that they do not like using many of the formal health care services due to judgmental and condescending staff, "some of the nurses, they're ignorant...probably because I'm native" (10:144, 148).

Table 33: Attitudes of Staff as a Barrier to Health Services

Theme #10b	
Label-	Attitudes of staff as a barrier to using health services
Definition-	Participants indicate that the way they are treated by staff at the health facilities acts as a barrier to their continued use of those facilities.
Indicators-	Statements reflecting perceived judgmental, biased or condescending behaviours by staff at the health facilities

This individual appears to be indicating that she gets poorer treatment due to her racial status. Another participant stated that: "then they got some nurses too, they're real miserable" (11:88-89). This same individual reflected that she felt health facilities treated her worse because she was "inner city" (11:221). One individual reflected: "I found the doctors there to be—how can I put this? —male

chauvinist pigs and think that they're God: they're above everybody" (4:106-107). However, out of the thirteen interviews only two respondents indicated that they felt discriminated or judged as different when accessing health care services.

The third sub-theme related to individuals who felt that their homeless situation was a barrier to getting and using adequate health services as described in Table 34. A few participants related that their homeless situation makes it difficult to manage their health care: "I'm supposed to see him (the doctor) right now, but I got to have a place; I can't carry pills around. Might lose them or something" (3:38-39). Another participant indicated that he missed his doctor's appointment at the HIV clinic because he came

Table 34: Homelessness as a Barrier to Health Services

Theme #10c	
Label-	Homelessness as a barrier to health services
Definition-	Participants indicate that their homelessness prohibits their use of health care system, and their ability to maintain some adequate level of health
Indicators-	Statement about their inability to make and keep appointments and or medication secondary to homelessness or substance use.

into the Spady for detox: "I went to this HIV-Hep C clinic downtown... I just missed it (my doctor's appointment). There's that doctor's appointment for that...at least I'm here" (8:131-132). He followed this statement by reflecting how difficult it is to even get an appointment for this clinic; "are they ever hard to get appointments ... specializes in HIV-Hep C" (8:135-137). This individual indicates that because he had to go to a shelter for detox that lasts four days,

he missed a very important and difficult to get appointment. In missing this appointment, and having difficulty getting a new one, and the good possibility of continued substance use and homelessness, one can only wonder whether this individual would ever make it to the clinic.

The majority of respondents indicated that in general they do not have a problem with using health care services. For example: "I had no problem (at the hospital). The staff was very nice people" (8:163), and "(I'm treated) like a king. That is my opinion. That's the way it is" (2:165). Another individual stated that "I was spoiled" (9:140) when she came into the hospital. A few others were not quite so glowing with their remarks but still felt that they did not have major issues with the health care services: "I was treated just as average as anyone else (in hospital)...oh the nurses are great (at Herb Jamieson)" (7:216,268).

Between Participant Analysis

In the next step, themes were compared across participants in order to identify themes that were shared across participants. As displayed in Table 35, a '1' indicates that the participant made statements that were consistent with the theme identified in the columns, An '0' indicates that the participant did not make any statements consistent with the definition of that particular theme in that column.

Table 35 clearly indicates that certain themes were more commonly reported across participants than other ones. The most consistent themes found across participants was theme #3, where all of the participants reported at some point in the interview that they

had reduced or limited contact with their children and or parents. Theme #4 was also very common, with the majority of the participants stating that they had a family history of alcohol or drug misuse. Theme #5 was shared by all participants; all of them reported a positive social support from their friends to continue substance misusing. Theme # 7 had the majority of the participants reflecting that they had a positive social comparison of their own health against that of their peers, and theme #9 where a majority of the participants indicated that they use health care services for emergency use only.

Themes 2,6,8, and 9 were represented in more than half of the participant's interviews. Most of the participants (10/13) reported incongruent health indicators (theme 8), while about half of the interviewees reported barriers to using health care services (theme 10), and positive perceptions of their own health (theme 6). Finally, about half of the participants reported some of the reasons reviewed earlier about factors that led them to become homeless. The only theme identified that did not have at least half of the respondents indicating its presence was theme #2 which reflected the reasons that the participants perceived that they were unable or had difficulty escaping homelessness. Theme #2 had just less than half of the participants stating why they have problems escaping homelessness, many of the participants who did respond, indicated that living on the street was their choice, it's where their friends are, and it allows them freedom.

Table 35: Between participant themes

Themes	Start of homeless ness	Escaping homeless -ness	Poor contact with family	Family substance use	Support for substance use	Positive feeling of health	Positive comparison of health	Dire use of health services	Barriers	Incongruent of health indicators
Int #1	0	1	1	1	1	1	1	1	1	1
Int #2	1	0	1	1	1	1	1	1	1	1
Int #3	0	0	1	1	1	1	1	1	1	1
Int#4	1	0	1	1	1	0	1	1	0	1
Int #5	1	1	1	1	1	1	1	1	0	0
Int #6	0	0	1	1	1	1	1	1	0	1
Int #7	0	1	1	0	1	1	1	0	1	0
Int #8	0	0	1	1	1	0	1	1	0	1
Int #9	1	1	1	1	1	1	1	1	1	1
Int #10	1	1	1	1	1	0	1	1	1	1
Int #11	1	1	1	1	1	0	0	1	1	0
Int #12	1	0	1	1	1	0	1	1	1	1
Int #13	0	0	1	0	1	1	1	1	0	1

Int = Interview, 1 =present or yes, 0 =not present

Relationships Among Themes

The final phase of the analysis attempted to integrate findings across thematic categories. The first two themes relate closely. Often the reason why an individual becomes homeless contributes to why they have difficulty escaping homelessness. The causes may be structural (loss of job, no affordable housing) and/or social (substance abuse, family problems, poor coping skills). Once an individual is homeless these same problems still exist, and if the individual has developed no new coping or management skills or received any kind of assistance (financial or psychological), the likelihood of this individual being able to escape homelessness is low. As well, once an individual becomes more entrenched within the homeless situation, the more difficult it becomes to escape (Grisby et al., 1990). These individuals are mostly around other people in the same situation that regularly use alcohol or drugs, and this perpetuates that ongoing use of alcohol or drugs and the homeless lifestyle. This relates closely with theme number 5, where individuals identified that their friends and peers use alcohol or drugs regularly, and that this supports their ongoing substance use. Thus themes 1,2, and 5 seem to cluster together around the factors contributing to homelessness making it difficult to escape from this situation. This analysis supports a mechanism for these efforts, namely that peer use of alcohol and other drugs can contribute to entrenchment within homelessness.

Themes 3 and 4 are closely related to each other in that many of these individuals demonstrate poor relationships with their biological family and that many of their family members also have

or had problems with substance abuse. Many of these individuals grew up with parents or siblings with alcohol or drug problems. It is not surprising that these individuals have problems with alcohol or drugs themselves, and that they chose or were forced to not have relationships with their family as well. Most of the participants reflected little to no contact with their family; thus, it makes sense that the participants would continue this pattern with their own children.

The family dynamics identified in themes 3 and 4 can relate to theme 5, in that with reduced family or outside support, respondents may be more likely to become homeless and more likely to use substances. Figure 1 displays plausible relationships between these themes, and suggests that each theme feeds back onto one another. With little family support, emotionally or financially, these individuals have less access to resources to prevent and escape homelessness. As well, with poor family relationships, it is likely that these individuals did not learn adequate coping skills to function in mainstream society.

Figure 1: Relationship Between Reduced Familial Support, Entrenchment into Homelessness and Increased Substance Use

Decreased Family Support	↔ Increased Entrenchment into Homelessness	↔ Increased / Substance Abuse

Themes 6, 7, 8, 9, and 10 all relate very closely to one another and these themes are the most pertinent ones in relation to the initial research questions. All of these identified themes reflect participants' views and perceptions on health and in accessing the

health care system. There was a discrepancy between theme 6 and 7, where some individuals did not perceive themselves as healthy unless they were comparing themselves to their peers. These respondents were in the minority, but a few participants felt that in general their health was not good, but when comparing themselves to their peers they felt they were. Statements confirming this are seen in the themes section. The individual that indicates he is Hep C and HIV positive initially feels that he has poor health, but when asked to compare himself to his peers relates that he is better off because he is not as thin and malnourished as other people he knows with the same disease. This indicates that there were a few individuals who did not initially compare their own health to the people around them, that they had a broader perspective and were capable of comparing themselves to others (or themselves) outside of their homeless niche. This information is contrary to Osborne's (1993) and Michalos' (1985) theories of social comparison as it demonstrates that some of these individuals do compare themselves to others outside of their immediate peers, but still choose to avoid health care facilities.

The above statements relate closely to Theme 8. Most of the individuals in the study indicated that comparatively, their health was better than their peers were; yet all reported multiple medical problems. Thus, most of the respondents demonstrated incongruencies between their actual health and their perceived health as compared to their peers. It is then understandable that if these individuals felt that their health was better than their peers, and didn't acknowledge the gravity of their illness or disabilities

that they would not see a need for using health care services. It could be surmised that if these individuals see themselves as healthy (because they compare their health to that of their peers) then they would be unlikely to use formal health care services. If the perceived need does not exist then the expected follow-up action (using health care services) would not happen. Thus, regardless of whom they compared their health to, if they felt that their health issues were not a problem then they will choose to not utilize health care services. Therefore, the perceptions of positive health (when in reality they may not exist) may function as a barrier to using health care services.

One may suggest that participants who compare themselves to their small, insulated peer group are less likely to perceive that they have health problems. In not perceiving that they have health problems, they may have little interest or perceived need to access health services for regular care or checkups. This would require further study to determine who these individuals are comparing their health to. Are the homeless always doing a downwards social comparison of their health, and if so why? Or, are there some homeless individuals who do an upwards social comparison? Or are there some who only compare their health to their own previous health status and not to the health of anyone else? These questions need to be posed and answered in order to gain a clearer picture of the social comparison process with regards to health perceptions.

Barriers to accessing services (theme 10) was a theme that can be related to emergent use of health care services (theme 9). Many of the respondents did not see a need to use health care

services on a regular basis to begin with, thus it is understandable that many of them felt no barriers to accessing services. The predominant theme concerning barriers to service was waiting lines, which is common among most of society, not separate for this group. The second predominant barrier theme was using health services for medications, this can be related to some individual's need to manage chronic illness symptoms (but not prevention) or the need to access drugs to sell or use for recreational purposes. The need to obtain drugs for recreational use fits in with the entrenchment into homelessness, and learning to adapt to the demands of being homeless. The need for medications to manage symptoms fits in that these individuals will get immediate treatment for symptoms but fail to access health services for prevention or maintenance; it's usually a last minute emergency. Interestingly, two of the respondents within the present study also stated that their primary use for health care was to obtain medications to sell. These individuals have learned to use the health care system to benefit themselves in ways other than their health.

Figure 2 relates Themes 8 and 9 in that incongruency of health indicators often was associated with decreased use of health services for ongoing medical issues, and greater use of health services only for emergencies or medications. There were three respondents who were congruent with their health indicators. One respondent felt she was ill regardless of comparison, another felt he was healthy compared to his peers, and both utilized clinics for medication/symptom management. The third perceived he was healthy regardless of comparison and used both clinics and acute

care facilities as needed.

Figure 2: Relationship Between In/Congruence of Health Indicators with Dis/Use of Health Services

Incongruence of Health Indicators	→	Decreased use of Health Services for Ongoing Medical Issues
Congruence of Health Indicators	→	Increased use of Health Services for Ongoing Medical Issues

These two themes (8 & 9) then relate back to the previous themes. The relationship between these themes could be interpreted as: if an individual had poor family relationships, never learned to value their health or see a physician regularly then what is the likelihood that they would do so as adult? As well, if an individual is entrenched in homelessness where obtaining food and shelter is a priority, health care may only be thought of in emergencies not for prevention or maintenance. It could be thought that in being entrenched with other homeless people who do not use health care services, there may be an influence onto other homeless people to not use health care services as well. The participation group was one where all individuals used alcohol or drugs, and one could postulate that once the participants became more involved in this lifestyle and began using alcohol or drugs more, (altering their senses) their perception of their own health may have become skewed, believing that their health issues were not a problem and therefore did not see a need to access health services. As well, if they are consistently

using substances knowing the health effects of abusing those substances, one must wonder how much they care about their own health overall.

All of these themes are intertwined with each other and cannot be totally separated from each other. Each one plays a significant role and has an effect on one another, some starting from the childhood of the participants to present day functioning. All of the themes work together in trying to understand the individual's situation of homelessness and poor health. One must look at all aspects of the themes and how they relate to each other. A single aspect or theme cannot change without affecting another, and in changing or altering only one theme the likelihood of success or change is limited.

Chapter 4

Discussion

Initial Research Questions Revisited

The first research question of this study concerned detailing the participant's history and use of alcohol and illicit drugs. The results provided information regarding amount of use, how individuals support their ongoing use, and when they initially started using. Some respondents provided information on family history and use, and the role of family and friends in their continued use. It was found that all of these individuals used either alcohol or illicit drugs within the past 30 days, most were daily users, others were binge users. All respondents considered themselves to have a problem with alcohol or drugs. The majority of respondents used alcohol primarily, with a smaller number using illicit drugs, and an even smaller number who regularly used IV drugs (1 out of the 13 respondents indicated using IV drugs regularly on the ASI questionnaire). All of these individuals used alcohol or drugs prior to becoming homeless, but did not state whether or not it became a problem before or after onset of homelessness. The majority of respondents indicated that they had family members who also had a past or present history of alcohol or drug problems (11/13 respondents). All of the respondents indicated that at present they have either reduced or no contact with biological family members, including their children. As well, all of the participants reported that their present friends and social supports are involved in alcohol and/or drug use and aid in the continued use of alcohol or drugs.

Many individuals relayed that with their friends they collect

money through panhandling, or collecting bottles to support the ongoing purchase and consumption of alcohol or drugs. Others indicated that they receive governmental supports, sell drugs themselves, or take odd jobs to financially support their substance use. None of the participants stated that at present they steal to support their habit, however, numerous respondents stated that in their past they committed crimes for money to purchase alcohol or drugs. Thus, the study was able to gain a basic understanding of the participant's history and use of alcohol and drugs, and was able to get an idea of family and friend roles within the homeless lifestyle and substance use. The first research question was answered with positive results of substance abuse, positive substance abuse support from family and friends, and consistent statements about substance use prior to homelessness.

The second question asked concerned determining these individuals' perspectives in accessing formal health care services. The results indicated that a number of these individuals were able to identify some barriers to accessing health care services. Only a few respondents indicated that judgmental or biased staff was a component, most indicated that waiting lines and inadequate numbers of staff were the biggest barriers to using clinics and ER services. However, one would suspect that waiting times would be the biggest complaint for the majority of the population, not just this group. No one indicated that location, distance, lack of medical coverage, language barriers, mistrust of health care service, or inadequate transport, were barriers. Only a small number of individuals indicated that it was their present homeless situation

that acted as a barrier to accessing health care services, primarily due to inability to store medications. None of our respondents indicated that they were unfamiliar with the acute care hospitals, local clinics or inner city services.

Finally, through a few statements made by participants, it appeared that inner-city/homeless services are not always coordinated well with each other. This may act as a barrier to accessing and using some of the services, depending on the immediate priority for the individual. Some individuals felt that getting into detox and having a place to stay for a few nights was more important than attending medical appointments. It can be difficult to get appointments with specialty clinics or doctors and the wait list can be long, the homeless lifestyle and the substance use is not helpful in being able to keep track of and make appropriate appointments. There needs to be a way for communication between agencies in order to coordinate services, allowing for the special circumstances and needs of this population.

The majority of respondents indicated that they didn't have a huge issue with the health care system, they just preferred not to use it and didn't see it as a priority for themselves. Thus, we can surmise that it is not the lack of service awareness, inaccessible location, inadequate medical coverage, or mistrust that prevent these individuals from using health services. The reason for decreased health service use must lie elsewhere, outside of the external and physical barriers.

The third research question of this study concerned the possibility of a social comparison process relating perceived health

and use of health care services. The results were able to answer whether or not these individuals perceived that their health was better than that of their peers. Results showed that the majority of respondents perceived that their health was not poor, and that it was better than that of their peers. Participants did not define what they perceived as healthy, however, they did relate what was unhealthy. Many of the examples that participants stated as being unhealthy were related to decreased ability to function in their environment (walking, breathing). These examples are consistent with what the interviewer (and data analyst) also perceived as representing poor health. However, the interviewer and analyst also included presence of chronic and disabling diseases and illness as examples of poor health.

Results also indicate that the majority of participants in the study do not access regular health care services. Few of these individuals see a physician regularly, and when they do it's primarily for pharmaceutical means and almost never for preventive means. We can also see that the majority of these participants only feel a need to access health care services for dire emergencies. One plausible reason that these individuals do not access health care services may be related to their positive perception of their own health when compared to their peers. Perceived positive health status relative to peers could mean that these individuals do not see any imminent health issues that they need to address, and therefore do not access services.

The study found that the majority of individuals indicated incongruencies between their perception of their own health and

their actual health status. Most participants felt that they had good health when compared to their peers, but when reviewing their other statements and upon observation, these individuals had numerous medical problems. These medical problems were most likely greater than that of the average person of the same age, but they still did not see themselves as ill or disabled and did not see a need for regular health care. The themes discussing perception of health and perception of health as compared to their peers provided information regarding social comparison of health among the participants. These indicated that a minority of respondents felt that their general health was poor, but in comparison to their peers, it was good. This reveals that there were a few individuals who did not initially compare themselves to their peers, but had a broader perspective. This is apparent in that there were respondents who initially perceived their health as poor yet when asked to compare to their peers felt it was good. However, the majority of participants felt that their health was good regardless of comparison to their peers, (indicating that they were likely comparing themselves to their peers already), and that they did not access health care services even though their medical needs were high. This then answers the question in that most participants did compare themselves to their peers spontaneously, and saw themselves as healthy when in reality they were not. Those who perceived that they were healthy, as compared to their peers, yet demonstrated incongruent health indicators were less likely to utilize health care services.

The results from the interviews were not able to conclusively

indicate that individuals automatically compared their health to that of their peers; however, it is implied. The writer's interpretation of the results lead one to question whether or not this is because these individuals are extremely resilient with regards to injury and illness or whether they do not view their health as an important issue. Or could it be that because of living on the street in harsh environments that these participants could rebound and bounce back from illness/injury without perceiving that it's a big deal, and thus not feel a need to get help for such a 'minor' problem. Or that some participants are too involved in alcohol, drugs, or finding a place to sleep, that their health is not a priority and thus not important, preventing them from accessing health services. Most likely it is a combination of the two that prevents most individuals from accessing services when they become ill or injured.

Other Results

There were numerous themes identified in this study that reached outside of our initial research questions. Information received from the study that was not part of the initial questions, included why some of these individuals became homeless and why they find it difficult to escape homelessness. Some of the participants indicated what it was that precipitated their homelessness, and why they have difficulties getting out of their homeless situation. All individuals used alcohol or drugs prior to becoming homeless, but none of them reflected that it was the sole reason for their homelessness. A few individuals reflected that being homeless was their preferred choice, and were making no real efforts to escape. Others indicated that it was a variety of things that could

not be separated. They identified both structural and social causes to their homelessness. Leads into homelessness were identified as family problems, loss of work, loss of home, alcohol use, and psychological 'break-downs'.

The participants indicated reasons why there were difficulties in escaping homelessness. The majority of causes indicated by participants were structural as inadequate housing, rents too high or not enough money received from social services or welfare. However, there were a few individuals that reflected that it was the continued substance use and the entrenchment into homelessness that made escape difficult.

It was interesting to find that some respondents chose to become homeless and/or chose to remain homeless. These individuals indicated some positive aspects of being homeless. Some respondents indicated that their homeless lifestyle provided them with extremely trustworthy and loyal friends that they did not have elsewhere, and that homelessness gave them freedom allowing them to move around, not tying them to one particular place.

It appears that not one specific reason can be identified as the sole cause to becoming homeless or in escaping it. It seems that a multitude of structural and social causes all play roles in the final outcome. There was definitely not one particular reason that was indicated for these individuals becoming homelessness; rather, there seems to be as many reasons as there are homeless people.

Another area that developed into a theme was limited and reduced contact with biological family. All of the individuals within this study indicated that they have limited to no contact with

biological family. A number of individuals spent time at residential schools or foster homes. Those that did live with their biological family often indicated poor family relations and presently no contact. As well, the majority of the participants who have children do not see them regularly, or do not know where or who they are. It appears that perhaps poor family relations while young not only relate to difficulty managing as an adult with possibilities of substance use and homelessness, but also the repeating of a pattern of disassociation and poor relationships with their own children and family.

Relationships between Present Results and Existing Literature

The initial literature review looked at 32 separate articles that investigated homeless populations. In comparing our group with the literature reviewed there were many similarities, but also a few differences. In comparison to Rossi's (1989) findings, our group was older (average age of 41 vs. 36 years), had been homeless longer (88 months vs. 26 months), and were a native minority (77% native vs. 46% black). In the literature it was found that 23-63% of the homeless population studied had substance abuse problems (Koegel et al., 1988; Wright et al., 1987); our study included 100% of the group having substance abuse problems. The present study only had one individual who reported regular IV drug use (as indicated in the ASI questionnaire) vs. Wright et al. (1987) who reported increased IV drug use among the homeless populations within their study. The differences were most likely due to sampling methods where recruitment sites were not inclusive of younger IV using individuals, and this study was purposeful in

including only those who used alcohol and/or drugs. Those who used the substance using shelters were long term chronic substance users with multiple medical problems who indicated that although few of them use IV drugs at present, many of them used IV drugs when they were younger. Similarities included that our group was predominantly male, had low levels of employment, and low-levels of education. Our intent was to investigate homeless individuals who have chronic substance use problems; thus, it is understandable that our demographics would be slightly different.

The literature also indicated reports of illness or injury among the homeless populations they studied. In our sample 100% of respondents indicated some sort of chronic illness or injury, only 15% reported some sort of psychiatric illness (depression and anti-social personality). This compares to 41% reporting a chronic disorder, 23% with injuries, and 29% with psychiatric disorders in other studies (Rossi, 1989). The other literature contained similar reports on illness and injuries. This study's group had higher reports of illness and/or injury than the literature, most likely due to the chronicity of homelessness and substance use.

The Edmonton Task Force on Homelessness (2001) reported that 40% of their homeless population was native with 70% of them living on the street. The present study confirms that many homeless individuals in Edmonton are aboriginal, and that many of the aboriginal homeless population of Edmonton use alcohol or drugs. It appears that the longer time spent homeless may be representative of a more entrenched and disaffiliated group, less likely to escape homelessness. Gregoire (1996) identified 8 sub-types of substance

users within homeless populations that run along a continuum. This study group appears to fall into the last group on that continuum representing an extreme group very entrenched within their present lifestyle. Gregoire (1996) describes this group as most likely native, high contact with other homeless people, >3 years homeless, they consume large amounts of alcohol, unlikely to report mental health problems or use drugs, and have poor physical health. This sub-group is inclusive of all of our respondents except that they have the odd use of illicit drugs. This sub-group helps to clarify our demographic differences as compared to Rossi (1989).

Grisby et al. (1990) describes the entrenchment and disaffiliation processes that occur within homeless populations. The present study group fits well into this process. With Gregoire's (1996) description of the sub-group it is obvious that this individuals fit with decreased social support outside of the homeless situation, increased affiliation with other homeless people, increased dysfunction, and increased functioning outside of traditional roles and norms leading to chronic homelessness (Grisby et al., 1990). Therefore, it fits as to why this study group may have had longer periods of time homeless, were primarily native, reported fewer psychiatric problems, and poorer health as compared to general homeless populations. It appeared that as these individuals became more entrenched and disaffiliated, that they become more accustomed to using the inner-city services available to them such as the shelters and meal providers. Therefore, it is easier to access these individuals for study purposes as compared to those living with friends or in abandoned buildings.

Numerous articles discuss the factors leading into homelessness, and attempt to reveal why individuals become homeless. The present study was unable to separate structural and social causes. Johnson et al. (1993) discussed two theories relating to this topic: social selection and social adaptation. Johnson et al. (1993), Koegel et al. (1988) and Winkleby et al. (1992) all support our findings that the two models are not mutually exclusive, and neither one can independently explain substance use and homelessness. The present study's results reflect that it is often a bi-directional and bi-causal theory that sees substance use and homelessness as risk factors for each other, not exclusive of each other.

Reduced use of emergency and general practitioner services within the substance using population is evident from the results and is consistent in the literature. Theories on medical service use indicated that need or illness was the greatest predictor of use (Padgett et al., 1990). However, Padgett (1995) discovered that substance-using individuals tend to have a reduced use of health care services, which is consistent with the results of the present study, regardless of their higher needs. Wood et al. (1997) also discovered that homeless people who were substance users were less likely to access general practitioners for basic prevention, treatment and follow up. This again is consistent with our study group.

The question is thus, why do these individuals with the greatest need for health services use them the least? The participants utilized the food and shelter services of the inner city agencies, which addresses some basic health needs, yet still were

reluctant to utilize formal health care services. Within this study, it appeared that the majority of individuals felt that their health was good as compared to their peers, and did not see an imminent need for health services. The prevention of illness and maintenance of their health was not viewed as a priority to the participants as they did not perceive their health to be poor, and thus health services were not used for prevention or maintenance. Osborne (1993) and Michalos (1985) theorized that when homeless substance users compared themselves to their peers that they saw themselves as relatively healthy, and therefore did not perceive a need for health care services. This theory supports this study's finding to a certain extent. The results indicated that these individuals knew they had medical problems, saw themselves as healthy compared to their peers, yet did not perceive a need to access health services.

Limitations of the Study

Initially, this study was going to attempt to sample from a variety of locations in order to get a broader recruitment; however, due to difficulties gaining access and safety of the interviewer, two of the sample sites were eliminated. Therefore, only two sites were included, narrowing down the recruitment and limiting the sample variation. The participants were all individuals who used an inner city shelter that is only designed for substance users. The RAH participants were found to also use and frequent this same shelter and were therefore very similar to those sampled from the George Spady Centre. There were very few individuals in the study who were young, used IV drugs, or who squatted or stayed with friends. It appears that these individuals do not frequent the shelters and/or

are not ill enough to access hospital services.

The depth or degree of information provided by the participants was at times limited. This is possibly the result of a combination of factors: inadequate time spent with the participants in order to gain rapport and trust. As well, limited information may also be a result of the participants having little to no interest in the topic being discussed or having never really thought about the topics prior to the interview. Without rapport or trust it is very difficult to get someone to open up and discuss personal issues. More than one meeting, or a constant presence in the shelter would perhaps reduce some of this mistrust or fear; however, many of these individuals have been on the street for a very long time and are not comfortable opening up with anyone. Thus, the depth of the information obtained was limited and restricted to a specific subgroup of the substance using population, thereby limiting any generalizability to substance using homeless populations as a whole. The participants all appeared to fit into a very specific group of substance abusing homeless people who are highly entrenched within the homeless lifestyle and had an extensive history and use of substances, primarily alcohol. The information obtained from this group could not be generalized to include regular IV drug users, sniffers, newer homeless people, or a younger population.

Another limitation is the possibility that a bias was created in the questions concerning perceived social comparisons of health. The question was phrased only to compare their health to that of their peers, the individuals were not asked to compare their health status to anyone else. This could lead to a response that was biased towards

a downwards social comparison. There is also the possibility that the individuals interviewed had a very different definition of 'healthy' than that of the interviewer. This could vary the interpretation of respondent's statements depending on the individual performing the analysis. However, respondents were clear when describing what they perceived was unhealthy, for example decreased functional status and presence of disabling diseases/illnesses. Many of the respondents referred to the presence of a disease, disability or injury along with reduced function as being 'unhealthy', which was not excessively different than the definition of healthy utilized by the interviewer.

There were also problems with the sound quality of the audiotapes, and therefore some transcripts were indecipherable. The poor quality was due to participants having very slurred or dysarthric speech, or by speaking too quietly.

New Questions and Future Hypothesis

The results indicate that these individuals know they have medical problems, see themselves as healthy compared to their peers, and do not perceive a need to access health services. Is this because they don't feel that health is important? Because they don't understand the consequences of their illness? Because other basic needs are more of a priority (food, shelter)? Because they don't care about the consequences of poor health? Are they too entrenched with the substance use itself that they cannot function well enough to use services adequately? Or if they are using so much will they be able to use any health services effectively unless they cut back?

If this study were to be replicated, it would be beneficial to

sample from a few different sites. For example the streetworks needle exchange, or recruitment off the street may reach some of the younger IV drug users and/or other sub-groups of homeless substance using individuals. However, these two sites may be difficult, as the individuals may be intoxicated or high at the time of contact.

It would also be of benefit to spend more time within a variety of the inner city agencies or on the street, to become a familiar face, a more trusted individual in order to gain rapport. As well, it would be beneficial to do the interview over 2 or 3 visits, in order to gain some trust with the individuals. These changes would hopefully allow for greater depth and variety of information. As well, providing grocery coupons was not the most appropriate form of remuneration for their time as these individuals do not have a kitchen, fridge or stove and get most of their meals through inner city agencies. As well, even though cigarettes can be purchased at a grocery store, the majority of the coupon providing stores are not within the inner city core and can be difficult for participants to get to.

The questions asked would be slightly varied the interview could take on a direction of its own to a certain extent with less structure, in order to delve deeper into individual concerns. Questions regarding why they feel they are in good health, examples, do the have concerns about their health, do they feel it is important or a priority at all. If it's not a priority, why not, what is more important? Questions concerning the social comparison process would also need to be addressed. One would need to

determine who the respondents are comparing their health to (if anyone), and the questions would need to be unbiased towards any specific comparison group. As well, there is a need to more clearly define what the participants view as 'health or healthy' as compared to what the interviewer and analyst view as 'health or healthy'.

Thus, from this study, it would be useful to continue pursuing a few different ideas. These ideas include, 1) is the lack of health service use and perceived positive health a resiliency that helps the homeless substance abusers survive on the street? Or do they have an actual disdain and lack of caring about their health? and 2) how many of these individuals choose to live and stay on the street and what is the attraction to doing so? What are the positives (if any) and the negatives to being homeless and is this an active choice based on their knowledge of the options they have?

The homeless substance abusing population of Edmonton appears to have a strong pull towards the alliances and relationships that form between them. According to the respondents these relationships are extremely binding and trustworthy. These individuals appear to depend and rely on each other on a daily basis. These relationships may act as the primary force as to why some of these individuals choose this lifestyle, not so much because they like to be without a home, but rather because their supports and friendships exist outside of a fixed address.

As a result of the study, it is apparent that there needs to be better coordination of inner city services, primarily between community and acute health services, and basic needs services (i.e. shelters). With improvement in communication between these

agencies, one would predict that there would be fewer individuals missing important appointments, it would allow individuals to reschedule easier and get appropriate medications, and to coordinate with social service and housing agencies more effectively. It would not necessarily require restructuring, rather a conscious effort and clear communication and coordination of service protocol when issues arise. This population is highly entrenched within this lifestyle and expecting radical changes is unrealistic. It may be of better use to look towards harm reduction, environment and social support for this group. Acknowledging that giving up alcohol and drug use entirely is unlikely, providing adequate housing and social programs that could fill the day-time needs, nutritional needs and nighttime needs would be appropriate.

It is difficult to make other concrete recommendations as the perceptual barriers of positive health that appear to occur within this population acts as a limiting factor. If the primary barrier to using formal health services is positive perceptions of health and thus 'no need perceived' then we should investigate, if possible, how to alter perceptions or if that is even warranted. It is also important to discern what the role of accessing basic needs is when discussing the utilization of formal health care services. If the priority is always for food and shelter and not for using health care services, then one must look to altering the social structure of the environment with regards to funding, adequate housing, and social support.

This study just touches on the questions concerning substance using homeless people and their health. There are still numerous

questions and ideas to be deciphered and answered; the greatest difficulty being the immense intertwining of possible issues that effect this population with regards to health and homelessness.

Appendix 1
Information Sheet

Title of Project: Homelessness, Substance Abuse, and Perceived Barriers to Accessing Health Care Services

Investigators: Karen Forss, University of Alberta (Masters of science student - 707-9429); Dr. Cam Wild, University of Alberta (492-9414)

A Student from the University of Alberta is working to understand some of the problems that drinkers and drug users have, especially when they have no home.

We will be asking anyone who drinks alcohol or uses drugs to talk in detail about their present and past life events. We will ask about your views on getting health services and the supports that you use when sick or hurt.

The talk will be done at a space in this building, or in a public place like a cafe.

The talk will last between 1-2 hours, and you can ask questions or talk about any worries once the talk is over.

Your name will be kept confidential; a code number will be used on the information sheets. No one will be able to link you with your answers, you can refuse to answer any question and you can stop the interview at any time. All information will be kept private, except when a code of ethics or the law requires reporting (such as child abuse, murder or rape).

There is no way to pick you out from the interview. Staff from the agencies involved, or from other agencies will not know what you have said. The study data will be kept in a secure area for 5 years after the study has been completed.

Your right to any treatment at any facility will not be affected by whether you finish the interview or not. The interview will cause no physical or mental harm.

We appreciate your honest answers to the questions. You will get a $20 grocery gift coupon for your time.

If you have any concerns about the way the study was done, you can call Doug Wilson at the Centre for Health Promotion Studies (492-9413).

Appendix 2 - Consent Form

Research Project Title: Homelessness, Substance Abuse, and Perceived Barriers to Accessing Health Care Services

Investigators:
Karen Forss, University of Alberta Master's of Science Student, (780) 707-9429
Dr. Cam Wild, University of Alberta, (780) 492-9414

Do you understand that you have been asked to be in a research study?
Yes/ No

Have you read and received a copy of the attached Information Sheet?
Yes/No

Do you understand the benefits and risks involved in taking part in this research study? Yes/No

Have you had an opportunity to ask questions and discuss this study?
Yes/No

Do you understand that you are free to refuse to participate or withdraw from the study at any time? You do not have to give a reason and it will not affect you access to care. Yes/No

Has the issue of confidentiality been explained? Do you understand who will have access to your information? Yes/No

This study was explained to me by:_____

I agree to take part in this study. Yes /No

_____

Signature of Research Participant Date Witness

_____ _____

Printed Name Printed Name

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

_____ _____

Signature of Investigator or Designee Date

A copy of this consent form has been given to you to keep for you records and reference. Thank you for your consideration and cooperation.

Appendix 3

Recruitment Information for Interview

Do you drink alcohol, take drugs or sniff inhalants? Have you not had a regular place of your own to live in for 10 out of the past 30 days? A student from the University of Alberta would like to talk to you about your experiences. All information will be kept confidential and won't be linked with you or your name. Interested? Call Karen at 707-9429/492-9413. Study approved by the University of Alberta ethics committee.

Appendix 4
Interview Guide

Part 1: Health Care Services

*1. Do you consider yourself healthy? Do you have any chronic illness or injuries?

Do you consider yourself more or less healthy than the people you hang around with? Give me an example of someone whose health is worse than yours.

*2. Have you ever been to the hospital? Which one? What for? What happened? Were you treated well? Would you go back again? Why/why not?

Can you give me an example of a time when you were poorly treated in the hospital? Can you give me an example of someone you've heard of having bad treatment in the hospital?

What do you consider very bad treatment? very good treatment?

*3. Have you ever been to a local clinic or have a regular doctor? Which one? Do you go for regular check-ups or only for emergencies? What for? What happened? Were you treated well? Would you go back? Why/Why not?

Can you give me an example of a time when you were poorly treated in the clinic? Can you give me an example of someone you've heard of having bad treatment in the clinic?

*4. Do you think that there could be ways to make services better able to help you? more accessible?

*5. What are the main reasons why you do/don't use health care services?

*6. Can you describe for me a typical day? what do you do/drink/eat in a normal day?

*6a. What do you think about people who go to the doctor all the time, just for check-ups or for little problems?

Part 2: History of Alcohol and/or Drug use

7. When did you first start drinking or doing drugs?

8. What is your Drink or drug of choice?

9. How often do you drink/use drugs? How much do you use?

10. What other drugs/substances have you used in the past? When was the last time you used them?

Part 2: Residency

11. Where have you stayed most nights in the past month?

12. How long has it been since you had a permanent place to live? Do you stay alone? Do the other people you stay with drink or use drugs?

13. When was the first time that you had no regular place to stay/live?

Part 3: Social Networks

14. Who do you hang out with most often? How often? Do these people drink/use as well? More or less than you? what drugs? drink?

15. Are there other people that you hang out with less often? How often? Do they drink/Use? More/less than you?

16. Are the people that you hang out with healthy? Do they have any problems or illness?

*17. Are the people you hang out with more or less healthy than you? Who could use health care services more...you or the people you hang with?

18. Do the people you hang with ever go to the hospital/doctor/clinic? Do the people you hang with ever help you out when you're sick? take you to the clinic or hospital? Do you ever take the people you hang with to the clinic or hospital or help them when they're sick?

Final:

** I'm just about done, is there anything about being homeless or staying in shelters that you think I should know or that you'd like to tell me?

APPENDIX 5

Budget Summary

Interview Remuneration:	$20.00/interview
Number of Interviews:	13 (x $20.00) = $260.00
Interviewer Salary:	$0.00
Stationary supplies:	$45.00
Total Budget Required:	$305.00

Appendix 6

Addiction Severity Index (ASI)

The ASI is a semistructured interview designed to address seven potential problem areas in substance abusing patients: medical status, employment and support, drug use, alcohol use, legal status, family/social status, and psychiatric status. In 1 hour, a skilled interviewer can gather information on recent (past 30 days) and lifetime problems in all of the problem areas. The ASI provides an overview of problems related to substance, rather than focusing on any single area.

Target Population

Adults

The ASI can be used effectively to explore problems within any adult group of individuals who report substance abuse as their major problem. It has been used with psychiatrically ill, homeless, pregnant, and prisoner populations, but its major use has been with adults seeking treatment for substance abuse problems.

Administrative Issues

Approximately 200 items, 7 subscales

Pencil and paper self-administered or interview

Time required: 50 minutes to 1 hour

Administered by technician

Training required for administration. A self-training packet is available as well as onsite training by experienced trainers.

Scoring

Time required: 5 minutes for severity rating

Scored by technician

Computerized scoring or interpretation available.

The ASI provides two scores: severity ratings are subjective ratings of the client's need for treatment, derived by the interviewer; composite scores are measures of problem severity during the prior 30 days and are calculated by a computerized scoring program.

Normed on the following treatment groups—alcohol, opiate, cocaine: public, private; inpatient, outpatient—and the following subject groups: males, females, psychiatrically ill substance users, pregnant substance users, gamblers, homeless, probationers, and employee assistance clients.

Psychometrics

Reliability studies done:
- Test-retest
- Split half
- Internal consistency

Measures of validity derived:
- Content
- Criterion (predictive, concurrent, "postdictive")
- Construct

Clinical Utility of Instrument

The ASI has been used extensively for treatment planning and outcome evaluation. Outcome evaluation packages for individual programs or for treatment systems are available.

Research Applicability

Researchers have used the ASI for a wide variety of clinical outcome studies.

Copyright, Cost, and Source Issues

Public domain—supported by grants from the Veterans Administration and the National Institute on Drug Abuse.

No cost; minimal charges for photocopying and mailing may apply. A free computerized scoring disk is provided with the training materials.

Copies of the ASI and related materials may be obtained from DeltaMetrics/TRI ASI Information Line: 800-238-2433

A computerized version of the ASI is available from : QuickStart Computer Company at 214-342-9020. Cost for the Base ASI Module is $990.

Source Reference

McLellan, A.T.; Luborsky, L.; O'Brien, C.P.; Woody, G.E. An improved diagnostic instrument for substance abuse patients: The Addiction Severity Index. *J Nerv Ment Dis* 168:26-33, 1980.

McLellan, A.T.; Kushner, H.; Metzger, D.; Peters F.; et al. The fifth edition of the Addiction Severity Index. *J Subst Abuse Treat* 9:199-213, 1992.

Supporting References

McLellan, A.T.; Luborsky, L.; Cacciola, J.; and Griffith, J. New data from the Addiction Severity Index: Reliability and validity in three centers. *J Nerv Ment Dis* 173:412-423, 1985.

McLellan, A.T.; Kushner, H.; Peters, F.; Smith, I.; Corse, S.J.; and Alterman, A.I. The Addiction Severity Index ten years later. *J Subst Abuse Treat* 9:199-213, 1992.

Hodgins, D.C., and El, G.N. More data on the Addiction Severity Index: Reliability and validity with the mentally ill substance abuser. *J Nerv Ment Dis* 180(3):197-201, 1992.

Stoffelmayr, B.E.; Mavis, P.E.; and Kasim, R.M. The longitudinal stability of the Addiction Severity Index. *J Subst Abuse Treat* 11(4):373-378, 1994.

INSTRUCTIONS

1. Leave No Blanks - Where appropriate code items: X = question not answered N = question not applicable
   Use only one character per item.
2. Item numbers circled are to be asked at follow-up. Items with an asterisk are cumulative and should be rephrased at follow-up (see Manual).
3. Space is provided after sections for additional comments

ADDICTION SEVERITY INDEX

SEVERITY RATINGS

The severity ratings are interviewer estimates of the patient's need for additional treatment in each area. The scales range from 0 (no treatment necessary) to 9 (treatment needed to intervene in life-threatening situation). Each rating is based upon the patient's history of problem symptoms, present condition and subjective assessment of his treatment needs in a given area. For a detailed description of severity ratings' derivation procedures and conventions, see manual. Note: These severity ratings are optional.

Fifth Edition

SUMMARY OF PATIENTS RATING SCALE

0 - Not at all
1 - Slightly
2 - Moderately
3 - Considerably
4 - Extremely

I.D. NUMBER

LAST 4 DIGITS OF SSN

DATE OF ADMISSION

DATE OF INTERVIEW

TIME BEGUN :

TIME ENDED :

CLASS:
1 - Intake
2 - Follow-up

CONTACT CODE:
1 - In Person
2 - Phone

GENDER:
1 - Male
2 - Female

INTERVIEWER CODE NUMBER

SPECIAL:
1 - Patient terminated
2 - Patient refused
3 - Patient unable to respond

GENERAL INFORMATION

NAME _____

CURRENT ADDRESS _____

_____

_____

GEOGRAPHIC CODE

1. How long have you lived at this address? YRS. MOS.

2. Is this residence owned by you or your family?
   0 - No 1 - Yes

3. DATE OF BIRTH

4. RACE
   1 - White (Not of Hispanic Origin)
   2 - Black (Not of Hispanic Origin)
   3 - American Indian
   4 - Alaskan Native
   5 - Asian or Pacific Islander
   6 - Hispanic - Mexican
   7 - Hispanic - Puerto Rican
   8 - Hispanic - Cuban
   9 - Other Hispanic

5. RELIGIOUS PREFERENCE
   1 - Protestant 4 - Islamic
   2 - Catholic 5 - Other
   3 - Jewish 6 - None

6. Have you been in a controlled environment in the past 30 days?
   1 - No
   2 - Jail
   3 - Alcohol or Drug Treatment
   4 - Medical Treatment
   5 - Psychiatric Treatment
   6 - Other _____

7. How many days?

ADDITIONAL TEST RESULTS

Shipley C.Q.

Shipley I.Q.

Beck Total Score

SCL-90 Total

MAST

_____

_____

_____

SEVERITY PROFILE

	PSYCHIATRIC	MEDICAL	FAMILY	ALCOHOL	DRUG	LEGAL	PSYCHOSOC	STATE
9								
8								
7								
6								
5								
4								
3								
2								
1								
0								

MEDICAL STATUS

*1. How many times in your life have you been hospitalized for medical problems? *(Include o.d.'s, d.t.'s, exclude detox.)*

2. How long ago was your last hospitalization for a physical problem YRS. MOS.

3. Do you have any chronic medical problems which continue to interfere with your life?
0 - No
1 - Yes _____
Specify

4. Are you taking any prescribed medication on a regular basis for a physical problem?
0 - No 1 - Yes

5. Do you receive a pension for a physical disability? *(Exclude psychiatric disability.)*
0 - No
1 - Yes _____
Specify

6. How many days have you experienced medical problems in the past 30?

FOR QUESTIONS 7 & 8 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE

7. How troubled or bothered have you been by these medical problems in the past 30 days?

Comments

8. How important to you now is treatment for these medical problems?

INTERVIEWER SEVERITY RATI

9. How would you rate the patient's need for medical treatment?

CONFIDENCE RATINGS

Is the above information significantly distorted by:

10. Patient's misrepresentation?
0 - No 1 - Yes

11. Patient's inability to understand?
0 - No 1 - Yes

EMPLOYMENT/SUPPORT STATUS

*1. Education completed *(GED = 12 years)* YRS. MOS.

*2. Training or technical education completed MOS.

3. Do you have a profession, trade or skill?
0 - No
1 - Yes _____
Specify

4. Do you have a valid driver's license?
0 - No 1 - Yes

5. Do you have an automobile available for use? *(Answer No if no valid driver's license.)*
0 - No 1 - Yes

6. How long was your longest full-time job? YRS. MOS.

*7. Usual (or last) occupation.

_____
(Specify in detail)

8. Does someone contribute to your support in any way?
0 - No 1 - Yes

9. (ONLY IF ITEM 8 IS YES) Does this constitute the majority of your support?
0 - No 1 - Yes

10. Usual employment pattern, past 3 years.
1 - full time (40 hrs/wk)
2 - part time (reg. hrs)
3 - part time (irreg., days/week)
4 - student
5 - service
6 - retired/disability
7 - unemployed
8 - in controlled environment

11. How many days were you paid for working in the past 30? (Include "under the table" work.)

How much money did you receive from the following sources in the past 30 days?

12. Employment (net income)

13. Unemployment compensation

14. DPA

15. Pension, benefits or social security

16. Mate, family or friends (Money for personal expenses).

17. Illegal

Comments

18. How many people depend on you for the majority of their food, shelter, etc.?

19. How many days have you experienced employment problems in the past 30?

FOR QUESTIONS 20 & 21 PLEASE PATIENT TO USE THE PATIENT RATING SCALE

20. How troubled or bothered have you been by these employment problems in the past 30 days?

21. How important to you *now* is counseling for these employment problems?

INTERVIEWER SEVERITY RATIN

22. How would you rate the patient's need for employment counseling?

CONFIDENCE RATINGS

Is the above information significantly distorted by:

23. Patient's misrepresentation?
0 - No 1 - Yes

24. Patient's inability to understand?
0 - No 1 - Yes

PAST 30 . LIFETIME USE

	Days	Yrs.	Rt of Adm.
(01) Alcohol - Any use at all			
(02) Alcohol - To Intoxication			
(03) Heroin			
(04) Methadone			
(05) Other opiates/ analgesics			
(06) Barbiturates			
(07) Other sed/ hypnotics			
(08) Cocaine			
(09) Amphetamines			
(10) Cannabis			
(11) Hallucinogens			
(12) Inhalants			
(13) More than one substance per day (Incl. alcohol).			

Note: See manual for representative examples for each drug class

* Route of Administration: 1 = Oral, 2 = Nasal 3 = Smoking, 4 = Non IV inj., 5 = IV inj.

DRUG/ALCOHOL USE

(14) Which substance is the major problem? *Please code as above or 00-No problem; 15-Alcohol & Drug (Dual addiction); 16-Polydrug; when not clear, ask patient.*

15. How long was your last period of voluntary abstinence from this major substance? *(00 - never abstinent)* MOS.

16. How many months ago did this abstinence end? *(00 - still abstinent)*

* (17) How many times have you:
Had alcohol d.t.'s
Overdosed on drugs

* (18) How many times in your life have you been treated for:
Alcohol Abuse
Drug Abuse

* (19) How many of these were detox only?
Alcohol
Drug

(20) How much would you say you spent during the past 30 days on:
Alcohol
Drugs

Comments

(21) How many days have you been treated in an outpatient setting for alcohol or drugs in the past 30 days *(include NA, AA)*.

(22) How many days in the past 30 have you experienced:
Alcohol Problems
Drug Problems

FOR QUESTIONS 23 & 24 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE

(23) How troubled or bothered have you been in the past 30 days by these:
Alcohol Problems
Drug Problems

(24) How important to you now is treatment for these:
Alcohol Problems
Drug Problems

INTERVIEWER SEVERITY RATING

(25) How would you rate the patient's need for treatment for:
Alcohol Abuse
Drug Abuse

CONFIDENCE RATINGS
Is the above information significantly distorted by:

(26) Patient's misrepresentation? 0 - No 1 - Yes

(27) Patient's inability to understand? 0 - No 1 - Yes

1. Was this admission prompted or suggested by the criminal justice system (judge, probation/ parole officer, etc.)

0 - No 1 - Yes

2. Are you on probation or parole?

0 - No 1 - Yes

How many times in your life have you been arrested and charged with the following:

- *(09) - shoplifting/vandalism
- *(04) - parole/probation violations
- *(05) - drug charges
- *(06) - forgery
- *(07) - weapons offense
- *(08) - burglary, larceny, B & E
- *(09) - robbery
- *(10) - assault
- *(11) - arson
- *(12) - rape
- *(13) - homicide, manslaughter
- *(14A) - prostitution
- *(14B) - contempt of court
- *(14C) - other

LEGAL STATUS

*15. How many of these charges resulted in convictions?

How many times in your life have you been charged with the following:

- *16. Disorderly conduct, vagrancy, public intoxication
- *17. Driving while intoxicated
- *18. Major driving violations (reckless driving, speeding, no license, etc.)
- *19. How many months were you incarcerated in your life? MOS.

20. How long was your last incarceration? MOS.

21. What was it for? *(Use code 3-14, 16-18. If multiple charges, code most severe)*

22. Are you presently awaiting charges, trial, or sentence? 0 - No 1 - Yes

23. What for *(If multiple charges, use most severe)*.

24. How many days in the past 30 were you detained or incarcerated?

Comments

25. How many days in the past 30 have you engaged in illegal activities for profit?

FOR QUESTIONS 26 & 27 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE

26. How serious do you feel your present legal problems are? *(Exclude civil problems)*

27. How important is it now is counseling or referral for these legal problems?

INTERVIEWER SEVERITY RATING

28. How would you rate the patient's need for legal services or counseling?

CONFIDENCE RATINGS

Is the above information significantly distorted by:

29. Patient's misrepresentation? 0 - No 1 - Yes

30. Patient's inability to understand? 0 - No 1 - Yes

FAMILY HISTORY

Have any of your relatives had what you would call a significant drinking, drug use or psych problem- one that did or should have led to treatment?

Mother's Side	Alc	Drug	Psych
Grandmother			
Grandfather			
Mother			
Aunt			
Uncle			

Father's Side	Alc	Drug	Psych
Grandmother			
Grandfather			
Father			
Aunt			
Uncle			

Siblings	Alc	Drug	Psych
Brother #1			
Brother #2			
Sister #1			
Sister #2			

Direction: Place "0" in relative category where the answer is clearly no for all relatives in the category; "1" where the answer is clearly yes for any relative within the category; "X" where the answer is uncertain or "I don't know" and "N" where there never was a relative from that category. Code most problematic relative in cases of multiple members per category.

1. Marital Status

1 - Married
2 - Remarried
3 - Widowed
4 - Separated
5 - Divorced
6 - Never Married

2 How long have you been in this marital status? YRS. MOS.
(If never married, since age 18).

3. Are you satisfied with this situation?
0 - No
1 - Indifferent
2 - Yes

4. Usual living arrangements (past 3 yr.)
1 - With sexual partner and children
2 - With sexual partner alone
3 - With children alone
4 - With parents
5 - With family
6 - With friends
7 - Alone
8 - Controlled environment
9 - No stable arrangements

5. How long have you lived in these arrangements. YRS. MOS.
(If with parents or family, since age 18).

6. Are you satisfied with these living arrangements?
0 - No
1 - Indifferent
2 - Yes

Do you live with anyone who:
0 = No 1 = Yes

6A. Has a current alcohol problem?

6B. Uses non-prescribed drugs?

7. With whom do you spend most of your free time:
1 - Family
2 - Friends
3 - Alone

8. Are you satisfied with spending your free time this way?
0 - No 1 - Indifferent 2 - Yes

9. How many close friends do you have?

FAMILY/SOCIAL RELATIONSHIPS

Direction for 9A-18: Place "0" in relative category where the answer is clearly no for all relatives in the category; "1" where the answer is clearly yes for any relative within the category; "X" where the answer is uncertain or "I don't know" and "N" where there never was a relative from that category.

9A. Would you say you have had close, long lasting, personal relationships with any of the following people in your life:

Mother
Father
Brothers/Sisters
Sexual Partner/Spouse
Children
Friends

Have you had significant periods in which you have experienced serious problems getting along with:

0 - No 1 - Yes	PAST 30 DAYS	IN YOUR LIFE
10. Mother		
11. Father		
12. Brothers/Sisters		
13. Sexual partner/spouse		
14. Children		
15. Other significant family_____		
16. Close friends		
17. Neighbors		
18. Co-Workers		

Did any of these people (10-18) abuse you: 0 =No; 1 = Yes

18A. Emotionally (make you feel bad through harsh words)?

18B. Physically (cause you physical harm)?

18C. Sexually (forces sexual advances or sexual acts)?

19. How many days in the past 30 have you had serious conflicts:
A with your family?
B with other people? (excluding family)

FOR QUESTIONS 20-23 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE

How troubled or bothered have you been in the past 30 days by these:

20. Family problems
21. Social problems

How important to you now is treatment or counseling for these:

22. Family problems
23. Social problems

INTERVIEWER SEVERITY RATING

24. How would you rate the patient's need for family and/or social counseling?

CONFIDENCE RATINGS

Is the above information significantly distorted by:

25. Patient's misrepresentation?
0 - No 1 - Yes

26. Patient's inability to understand?
0 - No 1 - Yes

Comments

PSYCHIATRIC STATUS

* (1) How many times have you been treated for any psychological or emotional problems?

In a hospital

As an Opt. or Priv. patient

(2) Do you receive a pension for a psychiatric disability?

0 - No 1 - Yes

Have you had a significant period, (that was not a direct result of drug/alcohol use), in which you have:

0 - No 1 - Yes	PAST 30 DAYS	IN YOUR LIFE
(3) Experienced serious depression		
(4) Experienced serious anxiety or tension		
(5) Experienced hallucinations		
(6) Experienced trouble understanding, concentrating or remembering		
(7) Experienced trouble controlling violent behavior		
(8) Experienced serious thoughts of suicide		
(9) Attempted suicide		
(10) Been prescribed medication for any psychological/emotional problem		

(11) How many days in the past 30 have you experienced these psychological or emotional problems?

FOR QUESTIONS 12 & 13 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE

(12) How much have you been troubled or bothered by these psychological or emotional problems in the past 30 days?

(13) How important to you now is treatment for these psychological problems?

THE FOLLOWING ITEMS ARE TO BE COMPLETED BY THE INTERVIEWER

At the time of the interview, is patient:

0 - No 1 - Yes

(14) Obviously depressed/withdrawn

(15) Obviously hostile

(16) Obviously anxious/nervous

(17) Having trouble with reality testing thought disorders, paranoid thinking

(18) Having trouble comprehending, concentrating, remembering.

(19) Having suicidal thoughts

Comments

INTERVIEWER SEVERITY RATIN

(20) How would you rate the patient's need for psychiatric/psychological treatment?

CONFIDENCE RATINGS

Is the above information significantly distorted by:

(21) Patient's misrepresentation?
0 - No 1 - Yes

(22) Patient's inability to understand?
0 - No 1 - Yes

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